THE HEALING PROCESS AND CONCEPTIONS OF ALCOHOLISM IN A DRUG DEPENDENCY TREATMENT CENTRE

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ABSTRACT

This study is concerned with the manner in which certain members of our society treat and conceptualize alcoholism. The setting of the fieldwork is an Atlantic Canada treatment centre for drug dependence. The focus of the Thesis is on the healing process during 5-Day and 28-Day Treatment Programs and the manner in which participants in these programs conceptualize alcoholism. Particular attention is paid to the "disease concept of alcoholism" in order to determine its role in treatment.

Findings suggest that alcoholism is variously defined, classified and explained by participants. There is also variation between healer clinical explanations of alcoholism and healer theoretical explanations. Treatment at the drug dependency centre is also shown to be culturally-specific in that it incorporates a "mental health" view of alcoholism in its components, and focuses attention on the individual as the locus of responsibility.

The implications of the results are relevant to theoretical and practical issues. Data show that there is ambivalence about the nature of alcoholism and its position in the medical system, as well as inconsistencies and contradictions in treatment. It is suggested that alcoholism is rooted in sociocultural conditions and that treatment should present

clients with systematic, comprehensive information about sociocultural factors influencing the epidemiology of the condition.

It is further suggested that if more sociocultural information is given to clients during treatment, clients will be better able to make necessary changes in themselves and better able to become involved in trying to change social conditions contributing to alcoholism.

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CHAPTER I

INTRODUCTION

Introduction

Definitions are a major problem in the field of alcohol research and treatment. The field is plagued by semantic confusion. A case in point is "alcoholism." While Alcoholics Anonymous, some researchers, treatment personnel, administrators and clients use the term freely, others disapprove of its use--and there is no universally-accepted definition of this key term. Furthermore, some workers believe the term should be abandoned in favor of a substitute term such as "alcohol dependency syndrome," while others heartily debate the pros and cons of such terms (see for example, Shaw 1979; Madden 1979 and Hodgson 1980).

A further problem is how alcoholism--or whatever it may be called--is to be classified. Should it be characterized as a disease, part of a psychiatric syndrome, a social problem, a moral failing--or some combination of numerous conceptions?

This Thesis examines the healing process and conceptions of alcoholism held by participants at an Atlantic Canadian Alcohol dependency treatment facility. The study focuses upon how alcohol-related problems are conceptualized by two groups of people in our society: clients and healers. A

second focus is upon how these different conceptions are reflected in and shape treatment.

During the study I attempted to identify conceptions of alcoholism held by clients, healers and other staff members. (The fieldwork and methods of data collection are discussed later in this Chapter.) I particularly tried to assess the "disease concept of alcoholism" in respect to its role in treatment. My goal was to see the extent to which the sickness concept is promulgated, the consistency of its application, and to assess positive and negative aspects of its application in the healing process.

Theoretical Considerations

The main theoretical importance of this investigation is its relevance to the study of comparative medical systems. The project is an examination of rehabilitation or healing--a core function of all medical systems and a much neglected research focus, particularly in its modern configurations (Kleinman 1973b).

The term "medical system" has been variously defined. Press, for example, defines a medical system as:

> A patterned, interrelated body of values and deliberate practices, governed by a single paradigm of the meaning, identification, prevention, and treatment of sickness (1980:47).

The internal consistency of a medical--or any other cultural system--however, should not be taken for granted. It is a

matter for empirical investigation. The treatment facility studied in this Thesis may be viewed as a microcosm of the larger medical system of which it is a part. With this assumption in mind the Thesis examines the degree to which there exists amongst healers themselves, and between healers and clients, a "single paradigm of the meaning, identification, prevention, and treatment" of alcoholism.

A first and critical step in the healing process is the recognition of a problem and a decision as to whether sickness, an inclusive term used here to embrace "disease" and "illness," is present or absent.[1] This study attempts to clarify the culturally-selective process by which members of a society designate a particular condition or behavior a sickness. Lieban (1977:21) stresses that there is:

> ...often marked variation in disease entities recognized from culture to culture...phenomena considered to be symptoms of disease by some groups may be regarded as signs of health or without medical significance by others.

He suggests that pinta (dyschromic spirochetosis) is a classic case in point. Amongst northern Amazonian Indians individuals whose skins are blotched are considered normal because the condition is so common, but the Western medical system recognizes this as a medical condition.

With regard to alcoholism, two problems complicate the decision as to whether disease is present or absent. First, use of the word varies culturally and sub-culturally. In Finland, for example, men working in isolated labour

camps come to towns every three or four weeks and engage in "explosive" binge drinking sessions during which much physical violence occurs. The Finns call this alcoholism. Jellinek (1960:16) comments, "While Americans [and presumably Canadians] would not call this alcoholism, we must admit that this constitutes a most serious problem and we cannot deny the Finns the right to refer to it as alcoholism." There is also sub-cultural variation in defining alcoholism. For example, Pittman & Snyder (1962:307) note that the lack of consensus is dramatically illustrated in a study of social agency and health experts' conceptions. Conceptions held by experts from psychiatry, social work, nursing, internal medicine, etc., accord with occupational biases. Thus the definition of alcoholism is problematic.

Second, whether or not alcoholism is a sickness is uncertain. Even the term "disease," if used as a synonym for illness, may be broken into "dis-ease" and used to refer to anything causing discomfort. There is a strong, if not growing tendency to conceptualize problems such as alcoholism, drug addiction and delinquency as sickness rather than moral, social or legal evils, as our society becomes increasingly "medicalized." But there is resistance to the sickness concept of alcoholism. Pattison, Sobell & Sobell (1977:37) comment:

> While the broad social advantages which have accrued from the traditional model--"alcoholism as a disease"--have been widely emphasized, there have also been resistances to the continuing extension of this model....Physicians resist the concrete analogy of alcoholism as a disease...Mental health professionals resist the concept of alcoholism as a biological state rather than a psychological development...Judges and lawyers resist the concept of alcoholism as determined by immutable forces which exculpate the alcoholic from legal responsibilities. Politicans resist the extension of alcoholism as a disease for which society must assume treatment, compensation, and liability responsibilities...

Room (1972:1050) notes, "The greatest irony is that the disease concept has triumphed just as its conceptual underpinnings are coming under seige." He claims:

> Already some general lines of attack can be seen in the literature specifically concerned with alcoholism; that the disease concept is often counterproductive in treatment...that the concept is vague and polymorphous and thus retards our understanding...that the disease label serves to justify an otherwise inadmissible interference in individual freedoms, tends to preserve the status quo and often results in treatment at least as coercive as frank "punishment"...that disease concepts are ill-equipped to deal with phenomena that are properties of social collectivities rather than of individuals... (Room 1972:1051).

The present study examines how alcoholism is defined and classified by two groups of people directly involved with the condition: healers and clients.

Etiology: Theories of Causation

Because classification implies an underlying causation and symbolic significance, this study also examines client and healer etiological views. It is often noted that our medical system differs from those of other cultures in that it specifies and emphasizes bacterial, physiological and like causes of sickness without much regard to the socio-cultural factors which figure so prominently in etiological theories held by members of other cultures. For example, Fabrega and Silver (1973:218) contrast Western biomedicine and Zinacatan medicine in the following terms:

Western

> Specific, identifiable causal processes of disease are known, and are identified by accumulated chemical and biological evidence. There is a separation between the causes, which are specified in a technical form, and social relations.

Zinacatan

> Generalized categories of illness exist, but they lack technical bases and precise delimitation. Categories of cause reflect and are reflected in social relations.

Glick (1967:36) also contrasts Western medicine and folk medical systems in similar terms. He writes that in contrast to Western ideas of causation, folk medical systems stress socio-cultural factors:

> The ethnographer who asks what causes illnesses is not likely to hear about bacteria or disordered physiology: instead he hears about competition, jealousy, greed, and lust; witches, sorcerers, and demons; mothers' brothers and grandfathers recently deceased.

Apropos this distinction between Western and folk medicine, this Thesis considers how healers' etiological theories use socio-cultural, psychological, physiological and spiritual factors. A further goal is to examine whether clients recognize socio-cultural etiological factors unmentioned or unstressed by rehabilitators. Although anthropologists (and others) devote attention to traditional healing practices, modern medical healing has remained largely unexplored until recently. My study provides a body of empirical information which helps clarify the actual Western healing process in this treatment context.

Myth and Stigma

Regardless of how alcoholism is conceptualized, individuals so labelled must come to grips with and adapt to customary beliefs, many of which are erroneous, and the stigma of the condition. Gussow and Tracey (1968) studied a group of leprosy patients at the USPHS Hospital, Carville, Louisiana. They discuss how the treatment process attempts to change patients' perceptions of their disease. The authors describe their attempts to de-mythologize and de-stigmatize leprosy by giving patients known medical facts and by

de-emphasizing the historical, social and medical errors and confusion which surround the disease. They write:

> It is a common fact of our observation that new patients hold expectations which compare leprosy with Biblical notions and include the fantasy of "total maximal physical illness" (p. 320).
>
> Scientific and medical data are adduced to show that leprosy historically has been mistakenly identified with a wide variety of other skin and nerve conditions and that for centuries it has been a general catch-all category for any number of deforming illnesses that have afflicted mankind (p. 320).

Thus this Thesis will also examine the means by which treatment may attempt to de-mythologize and de-stigmatize alcoholism. Medical systems provide illness with personal and social meaning through naming, classifying and explaining illnesses and, in a sense, healing occurs during each of these activities (Kleinman 1973b:161).

Fieldwork

The Atlantic province treatment centre where the fieldwork for this study was conducted serves the province's most heavily-populated counties and region, although the centre is attended by clients from other regions of the province, other provinces and other countries. The treatment centre is located in a city which forms part of an urban complex surrounding one of the largest and busiest harbours

in Atlantic Canada. The city has a population of approximately 75,000 people. Largely residential, the city is often referred to as a "bedroom town" for commuters who make their way daily to jobs in a nearby larger city (population approximately 130,000 people).

The "drug dependency" treatment centre and fieldwork setting is the main facility administered by the regional board of the Provincial Commission on Drug Dependency. Subsequently I refer to this facility simply as the "Centre" as participants commonly use this term to refer to the place. The Centre is located on the grounds of a psychiatric hosptial (referred to in the text as the "Hospital"), and, in fact, shares part of a building with the Hospital. Although physically part of the Hospital, it is administratively separate.

The Hospital

The psychiatric hospital has been on its present site for more than 100 years. It is located approximately three miles from the city-centre, set back from a main road and surrounded by sprawling lawns, playing fields and tall trees. Its location on the edge of the harbour provides a picturesque setting; beautiful views are offered by many of its seaward-facing windows. Some of the buildings which form the hospital complex are the original structures; others are recent replacements or additions. The older buildings are

red brick, and it is in one such building that the Centre is located. The Nurses' Residence, where I stayed during the fieldwork period from May 1st to July 31st, 1981, is one of the new structures--perhaps twenty years old. The most recent addition to the grounds is the Central Services Building which houses, among other things, a pool, gymnasium, lounge and the cafeteria.

A notable feature of the hospital grounds, but usually unseen by the visitor, is the network of tunnels which connect the main buildings. These tunnels conjure up images of a day in which the mentally ill were harshly treated. The tunnels are dimly lit, damp and relatively airless. There are also the remnants of dank windowless chambers in which, Centre clients told me--were locked the severely deranged in bygone times.

The major division among the kinds of people who frequent the Hospital complex is that between staff and patients. Students and other visitors are seen on the premises, of course, but the staff/patient dichotomy is primary. This is clearly seen in the cafeteria, where the seating area is partitioned by a series of room-dividers on which signs that read, "Staff Only," are displayed.

When I first entered the hospital setting--particularly the cafeteria--I had an uneasy feeling. Judging from the comments of new patients and first-time visitors, this seems to be a common initial reaction to the setting. One looks

around at the patients, wondering why they are there, how sick they really are, how to react to them, and how they will react to you. This is, in part, a function of being with people, particularly mentally ill people, who are the subject of a variety of negative cultural myths. It is also the usual result of being a stranger. Many anthropologists have commented on the feeling of being a stranger. For example, Newman in his ethnography of the Gururumba, a New Guinea tribe, writes:

> All of us at some time or another have been in the position of a stranger, not knowing what actions others expected of us nor what actions we could expect of others (1965:1).

One grows used to the cafeteria, however, and discovers that most patients look and act in a 'normal' fashion--although there are a few patients that are obviously physically and mentally impaired--and that patients seem to hold similar expectations of you as do others.

The Centre

As mentioned, the Centre is located in one of the old buildings in the hospital complex. It was formerly one of the psychiatric units--as attested to by its wide corridors (in which beds were sometimes set up) and nursing stations (Appendix II).

Although physically part of the hospital, the Centre and the rest of the hospital are separate. The Centre has its own special entrance identified with a large wooden sign, and it is virtually sealed off from the rest of the buildings--except for the tunnels. But there is also social separation. Patients from the Centre generally sit together for meals at the cafeteria, and interaction with the psychiatric patients is limited. Centre clients display some pity and concern toward psychiatric patients, but mainly humour and satire toward them. This humour captures and reinforces the separateness.

Their respective clients or patients also generate social distance between Hospital staff and Centre staff. One Centre staff member, for example, observed that psychiatric personnel claim that, "At least we don't get all the drunks and junkies!" While Centre personnel retort, "Thank God we don't have to work with the crazies!" This separation, although real in people's thinking, cannot be overgeneralized. There are referrals between the two facilities and I was told by a Centre staff member that sometimes the decision as to which facility an individual is admitted to depends on who conducts the initial assessment, i.e., Centre or Hospital staff. Usually a client stays at the facility at which he or she is initially assessed.

The Centre has three floors. On the first floor are administrative offices, a large conference room, and

counselling offices. On the second floor there is a Detoxification Unit and a smaller area devoted to the 5-Day "Treatment Orientation Program." The third floor is wholly devoted to the 28-Day "Short Term Treatment Program."

Following two brief reconnaissance visits to the Centre in December 1980 and March 1981, as mentioned earlier, fieldwork was conducted during the period from May 1 through July 31, 1981. Although a relatively short period, it was an intensive data gathering experience. It involved being in the cafeteria by about 8:00 a.m. to eat breakfast, attending at the Centre all day, and returning in the evening--sometimes very late into the night. This pattern continued from Sunday night until Friday noon, at which time clients were discharged for the weekend (with the exception of Detox clients). Fortunately, during my stay I was able to live at the Nurses' Residence, which is conveniently located on the Hospital grounds.

Information was gathered through participant observation and interviews--sometimes with a tape recorder.[2] Apart from the Detoxification Unit (which I did not study), there are two treatment programs operating at the Centre. All but approximately one week of fieldwork was spent in the 28-Day Program; the other week was spent in the 5-Day Program. After two months in the 28-Day Program, I sat in on the 5-Day Program, after which I returned to the 28-Day Program.

Staff and clients were helpful and encouraging. Clients, in particular, seemed only too willing to tell me of their problems and how they came to be at the Centre. And staff, no doubt because they are used to having social work, nursing, medical and other students on the premises, treated me as a fairly natural part of the scene. At times I felt torn between loyalties. Because I did everything possible with the clients (for example, participated in Yoga, watched films, attended group therapy and played softball), I came to feel, and was largely accepted by clients, as more of a client than a staff member. Staff, however, seemed to consider me closer to themselves than to clients, and would invite me to lunch, attend staff meetings, perform staff duties, etc. Each group was, I believe, somewhat suspicious whenever I was with the group. One client, with whom it was particularly difficult to establish rapport, initially jokingly referred to me as a spy--presumably a staff spy. One of the counsellors, on the other hand, kept chiding me about spending so much time with clients, kept coaxing me to eat lunch with staff, and to give the clients a break and leave them alone. So I often felt acutely aware of the difficulty of trying to be accepted by both groups in order to obtain as close as possible an "insider's view" of both groups. This problem was never really solved, as my affinities naturally inclined towards the clients--perhaps due to an anthropological

affinity with the perceived "underdog." On the other hand, I realize that the staff have an enormously difficult job and the staff members I met are exceptionally dedicated and capable people.

Practical Relevance

The Thesis has relevance to practical issues. In particular, information in the Thesis may be useful to Newfoundlanders who in April, 1982 passed legislation to establish The Alcohol and Drug Dependency Commission of Newfoundland and Labrador, and who now plan to set up full-scale treatment facilities. Practical issues are discussed in Chapter V of the Thesis.

Summary

This study focuses upon the healing process at a treatment centre for alcoholism in Atlantic Canada. It attempts to identify client and healer conceptions of alcoholism and their role in the healing process. In particular, it examines the sickness concept of alcoholism. Results of the study are relevant to basic theoretical issues concerning medical systems and have practical implications in the field of treatment.

In Chapter II following, Centre treatment programs are described in terms of their goals, philosophies and components, and what I observed happening in these programs.

Chapter III then discusses the healing process at the Centre; it identifies universal and culturally-specific features of this process. Client and healer conceptions of alcoholism are focused upon in Chapter IV. Finally, Chapter V summarizes information in the body of the Thesis and identifies theoretical and practical implications of the data. Practical implications are discussed here via-a-vis Newfoundland.

NOTES

1. These terms have been contrasted by many authors. Typical is the following discussion by Field (1976:334):

> 'Disease'...refers to a medical conception of pathological abnormality which is indicated by a set of signs or symptoms. 'Illness' on the other hand refers primarily to a person's subjective experience of 'ill health' and is indicated by the person's feelings of pain, discomfort, and the like.

2. A consent form, approved by the administration of the Centre, was signed by each client. This form enabled clients to agree or disagree to participate in the research. See Appendix I for a copy of this form. It should be noted that none of the clients refused to sign the form.

CHAPTER II

THE TREATMENT PROGRAMS

Introduction

This chapter describes the two main programs at the Centre: the 5-Day Program and the 28-Day Program. It describes formal statements of treatment components, goals, philosophy and objectives, and observed practices. Throughout this presentation client and healer conceptions of aspects of alcoholism emerge in the treatment context to augment those in Chapter IV.

The analysis following presentation of data on the two programs focuses upon identifying main components and conceptions in the treatment programs. The 5-Day Program may be looked upon as an attenuated version of the 28-Day Program.

The 5-Day Treatment Orientation Program

When I first arrived at the Centre in May, I attempted to arrange observing at two sessions of the 5-Day Treatment Orientation Program before going upstairs to the 28-Day Short-Term Treatment Program to see what many clients are exposed to before entering the latter program. This proved impossible since there was apparently no space available in the 5-Day Program for me at this time. The

brochure for the 5-Day Program states: "The bed capacity for the Treatment Orientation Program will not exceed ten (10), (including a maximum of 2 Day Care)." I was surprised and disappointed, therefore, to discover that only three clients would be taking the 5-Day Program with me when I did arrange to sit in on it during the first week of July, 1981. The previous week there had been ten to fifteen clients in the program. Several staff members commented on the unusual paucity of clients, speculating on whether it was due to good summer weather, because it was a holiday week, or just incidental.

As it turned out, two other clients joined the program--one only stayed for one day, and the other showed up two days late. Since the basic group is so small, the members are briefly described:

Clients

Ron — A tall, fair-haired 45-ish looking man with boyish features but weathered face. He is a dockyard safety inspector and also involved in St. John's Ambulance First Aid. He admits having a long-standing alcohol problem, and took a treatment program in 1975 or 1976. He was sober afterwards for some 3½ years but gradually began drinking again until for the two weeks prior to coming to the 5-Day Program he had been intoxicated daily. Ron has a wife and one child.

Jack — A stocky, medium-sized man who looks in his forties but is only 32 years old. He is fairish in complexion with lots of freckles. He emigrated to Canada from Norway when he was 24 years old and speaks good English with a slight accent. He is a technician on a cargo ferry, working one month on duty, and one month off. He has a wife and one young child.

Dwayne An extremely quiet and unexpressive man--or was so for all but the last day or so of the program. He is in his thirties and has considered himself an alcoholic for a number of years. An active Alcoholic Anonymous member, he claims to have lost a wife and two children through alcoholism, and seems very lonely. He is taking the program because his boss threatened to fire him if he did not stop drinking; he works in a printing shop. He is small, somewhat frail and unhealthy-looking and is missing several teeth.

Josephine A tall, blond, Dutch woman in her late forties or so. She is attractive and well-spoken. She acts as though she is carrying a chip on her shoulder, and has recently lost her mother through death and her husband through divorce. She left the program after the first day.

Greg A tall, well-built, handsome man in his early thirties. He is from a small coastal community some miles from the Centre. He is rather quiet, but has a pleasant manner. His first marriage ended disastrously when his wife died at age 25. He has one son from his marriage, is now re-married and has two more sons by his second wife.

Staff

Carol About forty years old, is shortish and rather heavy-set. She has a nursing background and is presently in charge of the Treatment Orientation Program. She is pleasant and easy to talk with.

Paulette Paulette is a lovely Black girl from South America. She looks about 20 years old, but is actually in her mid-thirties. She has lived in Canada for about seven years, works as a nurse and is also completing a Master's degree in social work, her weeks at the Centre constituting her final practicum.

These people, together with myself, comprised the group during the 5-Day Program. Other staff members occasionally gave lectures or talks, and group members also attended films and lectures with clients from the 28-Day

Program, together with a few clients from Detox.

Goals and Objectives of the Program

As stated in the brochure presented to group members at the beginning of the program (See Appendix III, p. 168), the program seeks to present to patients "concepts, information, and support, when, if acted upon will assist the patient in the recognition of their [sic] condition." It also attempts to reinforce the idea that the patient must be the "prime mover" in his or her own recovery. The program further aims to encourage patients to "cope constructively with their current situation, and assist in the overall assessment process." Patients will be helped to "face reality and function more responsibility. In a nutshell, the program's goals and objectives are as follows:

> The goal will be to facilitate self appraisal in their present milieu with the aim of encouraging constructive behavioral change via ongoing educational support and participation in the various treatment programs available.

The following paragraphs describe some of the means by which staff members attempt to implement these goals and objectives, and unpredicted consequences of their actions vis-a-vis clients. In short, the following section presents a picture of what happens during the program, from the viewpoint of a participant/observer.

What goes on in the Program

The program takes place primarily in two rooms. One is a small lounge used for group discussions and 5-Day Program lectures. The other, an adjoining room, is larger and used for relaxation exercises, films and lectures. The latter two events are often attended by clients from other programs at the Centre. These two rooms, together with the nearby Detox kitchen, are where clients of the 5-Day Program spend most of their time. The co-ordinator of the program, who also provides individual counselling, has an office adjacent to the lounge. These rooms are at the far end of one of the corridors on the second floor of the Centre. As mentioned previously, most of this floor is the Detoxification Unit or 'Detox,' and there is no barrier between Detox and the 5-Day section of the floor. Five-day clients are free to wander into Detox and must pass through it on their way on and off the floor. Both groups of clients also share common facilities such as bathrooms, the pool room, and the kitchen. (See Appendix II, pp. 162-165).

Atmosphere

The atmosphere is informal and relaxed. People generally dress casually, use slang and profane language, chat informally or "horse around." Five-day Program clients have access to a TV lounge and games room, and many of them spend considerable time merely sitting in the kitchen,

drinking coffee and chatting. To illustrate the informality of the place, I will describe my first visit to the Detox kitchen. There were about five men in the kitchen at the time quietly sitting having coffee. I made myself a coffee and sat with Bob, one of the Detox clients. I told him who I was and he told me a little bit about what he did for a living and why he was in Detox. At another table sat two men, one of whom, after a few minutes, called over to Bob: "Is that your old lady, Bob?" Bob answered, "Yeah." We continued talking and a few minutes later he called over again and politely said to me, "I don't think you're supposed to be in here, Miss. There's a visitor's room down the hall." Bob then said, "That's O.K. She can stay here." Bob seemed to delight in leading the others on to think I was his wife or girlfriend, or his "old lady," and it wasn't for some days that the man sitting at the other table discovered that I was not. Another event occurred that morning in the kitchen. A Detox patient, a very shaky man of perhaps fifty-five or sixty, discovered the large stainless steel milk dispenser was empty and decided he would attempt to put in a new carton. To put it mildly, he had trouble accomplishing this task and squirted the milk all over the floor, himself and the dispenser. The other Detox patients thought this was absolutely hilarious and made no attempts at all to help the fellow who was kind of laughing but also seemed embarrassed and somewhat

self-conscious. A stream of profanities emitted from his shaky mouth. When a cleaning staff member eventually appeared at the scene she good-naturedly asked what had happened, nonchalantly began to clean up the mess and commented that she had seen a lot worse messes than this one.

Schedule of Events and Content of the Program

On the last page of the brochure in Appendix III is a schedule of events. This is included to give the reader an idea of the scheduling of events and free time during the program. The schedule is not always closely followed. For example, on the first morning of the program I was told to arrive at about 9:00 a.m. One of the clients, Josephine, was told likewise to appear at that time. She was most upset and annoyed that she had rushed to the Centre from her home in an outlying suburb, only to find she had to wait for organizational matters to be performed and the program would start late. Also on the last morning of the program one of the staff members began a lecture on the medical aspects of alcoholism. About five minutes after the talk had begun, someone came to the door and told us a dietitian over at the Central Services Building was waiting to give a talk on alcoholism and nutrition, so we all trooped over to the other building. Program scheduling, then, is flexible.

In the program's brochure the contents are listed under the following headings:

(A) Education
(B) Work Therapy
(C) Group Discussions
(D) Evening Programs
(E) Films
(F) Recreation
(G) Relaxation Therapy

Each of these categories of activity will be discussed in turn.

Education

The brochure for the program lists six lectures under this heading. Presentations given during my stay in the 5-Day Program will be briefly described below.

The first real event on the agenda was a lecture by Peter, a staff member and recovering alcoholic. His position at the Centre is called "Community Health Worker." Peter is a charismatic person. He commands attention by using a lot of eye contact, showing interest in people by asking their names and how they feel, speaking softly, almost intimately at times, and at other times emphasizing a point by bellowing. He seems to be constantly attempting to gain people's trust and professing interest in their problems--and this seems "to work" with most clients. During his talk he recounts illustrative stories about drinking, some humorous, some pathetic. He intimates he is an alcoholic, although I did not hear him use the term in

connection with himself. He does, however, say things like, "I know I've been so God damn drunk I couldn't even crawl, much less drive a car!" Another staff member told me, however, that Peter is an alcoholic.

Peter talks about alcoholism as a "disease of feelings." He characterizes it as a "progressive, chronic, primary and fatal" sickness in which the alcoholic person develops "a denial system," "a faulty memory system" and "a world of delusion." He says the alcoholic person develops a dependency upon alcohol and drinks just to feel normal, although this becomes increasingly difficult to maintain and he or she begins to feel badly most of the time.

Peter's talk, then, is aimed at clarifying the nature of drug dependency, particularly alcoholism. It especially attempts to clarify how alcoholism affects a person's feeling states and how it functions to disrupt social and other relationships. The effect of the lecture seems to be to shock clients into seriously considering the emotional consequences of their drinking or drug taking. Clients are encouraged to recognize and express their feelings, and to be honest with themselves and others in order to free themselves of the consequences of a very serious illness. The lecture is emotion-laden. This is partly due to the content of the discussion and partly achieved by Peter's very personalistic style. Peter is skilled at capturing people's attention,

drawing upon their needs for affection and understanding, and attempting to reassure them he is honest and giving--and they should be likewise.

On the second day of the Program there was a presentation by Carol. The topic was two drugs, Antabuse and Temposil. These interact with alcohol to make the person who drinks while taking these drugs quite ill. She discussed how the drugs work and the relative qualities of the drugs. Jack was sceptical about using either of these drugs. Carol tried to convince Jack they were good crutches, as long as used with other follow-ups. I sensed a moralizing challenge in Carols' words, "Well, if I was trying to stay sober and was an alcoholic, I'd take Antabuse, go to A.A., out-patients--anything and everything to stay sober!" Dwayne then testified to the effectiveness of Antabuse. He said he had drunk two draught beer while on Antabuse and ended up in hospital getting his stomach pumped out.

On the third day of the Program there was a talk by Barry, one of the attendants in Detox. The subject of his lecture was Follow-up. He listed the following methods as important in follow-up programs:

Will power
Antabuse and Temposil
Alcoholics Anonymous and Narcotics Anonymous
Out-patient counselling
28-Day Short-Term Treatment Program
Sports
Work

Community Affairs
Family
Church
and Character Change

Barry claimed that, with the possible exception of Alcoholics Anonymous, no one of the above would keep a person sober--and least of all will power, which he considered "next to useless"--even though it tops his list. He said in order to maintain contented sobriety one must undergo a character change.

On the next day, Sheila, another Community Health Worker and recovering alcoholic, talked about drug dependency and recovery. One of her comments was that each client must face the realization that social drinking would be impossible. She said, "It was for me." Another comment she made was that the only value of will power in staying sober, was the will power to refuse that first drink--"after that booze takes over."

On the last day of the program one of the staff members began a lecture on the medical aspects of drug dependency. However, this was cancelled in favor of a talk and slide presentation by a dietitian attached to the Hospital. The topic of the lecture was alcoholism and nutrition. She passed around an article on this subject in a scientific journal, "Nutrition Today," which showed severe effects of malnutrition due to alcoholism. She presented facts about nutrition and alcoholism--many of which were frightening, then she showed a slide presentation that went over the same

facts in graphic form. It consisted of cartoon-like sketches on slides with a spoken narrative to accompany each slide. Afterwards I stayed and talked with the dietitian for a few minutes. I asked what she might do if drug addicts as well as alcoholics were in the audience, since the whole slide presentation, as well as her talk, were directed toward the problem of alcoholism. She said it was her understanding that the effects of alcohol and other drugs vis-a-vis nutrition were basically the same, so all that had been said about alcoholism could apply to other types of drug abuse as well. One point she made was that alcoholism could lead to malnutrition, which in turn could lead to craving for alcohol. She therefore encouraged clients to eat properly and avoid being hungry which could trigger craving.

Work Therapy

According to the schedule of events a certain amount of time during the Program is to be devoted to "Work Therapy." This normally consists of each client being assigned a small task such as taking out bags of garbage, wiping over tables and counter tops, or washing a few spoons and plates. I did not, however, observe any 5-Day Program clients performing Work Therapy activities. Since some of the cleaning staff members were on holiday, this portion of the Program may have been temporarily omitted.

Group Discussions

According to the brochure, the philosophy or goal of such group discussions will be to confront the client with reality and support concrete plans that will pertain to continuing sobriety.

The first session of Group Discussion was brief. It consisted of Carol outlining what the group could expect over the coming week and her expectation that clients would attend all functions and participate fully.

The first real Group Discussion got underway on the afternoon of the first day. Carol asked clients how they came to be at the Centre. Ron said he just came on his own, since for the last two weeks he had been drunk every day. Carol questioned whether he had totally come on his own and he said, "Yes, I did." Jack said he had come because his last couple of drunks had scared him; he said he had felt absolutely miserable afterwards. Dwayne said his boss had told him it was either treatment or he would be fired. Josephine talked about all her troubles and how she believed her drinking was a response to them. She said, "I just can't cope with them." Josephine had sought out a Community Health Worker who recommended she come to the Centre. During this discussion period, Carol and Paulette and myself generally sat back and listened to what the others had to say. They each talked a bit about themselves and why they were at the Centre, but people seemed guarded about how much they would reveal, and Carol and Paulette

did not probe too deeply on this first meeting.

On the second day of the program instead of the regular Group Discussion there was a "Special Group." This is a meeting conducted by a clergyman, but is called "Special Group" in order to disguise the spiritual nature of the discussion which might arouse suspicion in clients and discourage attendance.

The clergyman, Bob, talks about his personal experiences with alcohol. He stopped drinking some twenty years ago after experiencing a kind of spiritual awakening. In his youth and early twenties he claims to have been a heavy drinker, an alcoholic. After leaving his parent's home he was plagued by guilt for the trouble he had caused and always meant to apologize to his parents, especially to his father, although he never did so. He went back home, however, and shortly thereafter his father had a heart attack; he was driving his father to the hospital when his father flopped over on his shoulder dead. Shortly afterwards Bob was completely overcome by guilt and one day while driving along in his car something made him pull over to the side of the road, weep profusely, and ask God to forgive him. From that day forth he has never touched a drop of alcohol. He claims never to have been a religious man up to that episode, but decided to devote his life to religion and become a minister of the Baptist Church. He talked about God as love, and that each of us, in order to be unburdened

of sin, had to find some form of God we could believe in and surrender ourselves to this God. Bob said he believes that all people have a kind of instinct to believe in the supernatural, and that is why religion is universal.

After Bob's talk, I stayed behind and chatted with him for a few minutes. I told him that, as a non-believer, I objected to his identifying God with the supernatural. He told me, as before, that he believed that God is love and that to him the supernatural is anything that is unexplainable. I felt satisfied with this explanation and told him so. He was obviously pleased and said, "Well, maybe I've given you something to take back to Newfoundland with you, that you didn't have before."

In the afternoon another session of Group Discussion was held. None of the clients seemed very talkative at first, and Carol reminded the group that it was up to them to bring up issues they wanted discussed, and staff was only there to guide discussion. After a few lengthy silences clients began to talk about what they had experienced so far on the program, how they were feeling, etc. In response to a comment by Jack about non-alcoholics not being fully able to appreciate what alcoholics go through, Carol launched into a discussion of her pet peeves. One of these is that non-alcoholics (she is a non-alcoholic) cannot understand what alcoholics go through. She suggested that we all have life experiences that can prepare us to empathize

with one another, and that one need not be an alcoholic to help and understand alcoholics. Another pet peeve is that alcoholics should "come out" instead of remaining anonymous and thereby perpetuating stigma. She claims that perhaps if an alcoholic ran across the country as did Terry Fox--or performed a similar feat--alcoholics might be more accepted.

During this discussion Ron was talking about how he had begun drinking again and decided to come to the Centre "to straighten himself out." After a few questions about his decision to come to the Centre, Carol confronted Ron with, "Isn't it true that you're a mandatory referral from work, Ron?" Ron denied that he was. Carol said it was her understanding that he had been referred from his employer. Ron again denied this and continued talking uneasily. After the group meeting Ron went in to see Carol, upset with her accusations and wanted to know exactly where she got the idea he was a mandatory referral. Later he mumbled something about going in to see the company nurse a few times and developing a friendship with her, but he denied there had been any coercion on the part of his employer to attend the Program.

In talking to Carol privately the next day, I asked her about the concept of denial. She told me, "Oh, yes. There's a lot of denial among clients." I then asked her how she could tell whether a client was denying or not, because I certainly could not spot it. She wavered on this

point, or was at least vague, then pointed to Ron, saying, "You can just see he's doing a lot of denying." She went on to say, however, that Ron had come in to see her quite upset about the previous day's confrontation, and that one had to be very careful about one's facts before confronting a client. She said she was going to check further into the matter of Ron's referral because she was not absolutely positive of her facts, and just how much Ron was supposed to be informed about the referral. I left her office feeling uneasy about the whole business of confrontation and denial.

On this third day of the program a new group member appeared: Greg. After he had been in Group Discussion for a few minutes, Greg was asked the same questions that had been put to the other group members on their first day. He said he had come to the Centre on his own after lying around on the beach drinking beer and feeling miserable about himself. He said he realized that all his activities included booze. His remarks were passed over momentarily. Then Carol began to talk about the crises that bring people to the Centre. She said, addressing Greg, "Nobody just wakes up one day and decides to come to the Centre;" something has to precipitate that decision. Greg mumbled that his wife drove him to the Centre, but he came on his own, without coercion. He was, however, obviously taken aback and seemed embarrassed by Carol's reaction to his

statements. I felt she had been unfair to him. After all, the other group members had at least had a chance to get used to the place before having their statements challenged. Later I discussed Carol's handling of Greg with Jack, another 5-Day Program client. Jack felt Carol had not been hard enough on Greg. This is how he responded to my questions:

> Q. Do you think Greg was telling the truth yesterday in group, about his coming to the Centre...?
>
> A. He never gave a straight answer on that either....
>
> Q. Well, that's what I was wondering. Do you think Carol was too hard on him?
>
> A. No. She should have been much harder on him. No, he wasn't being honest, you know, and if the program's gonna work for you, you have to be honest. Because if you're not honest with yourself, you cannot be honest with others.

Obviously our opinions on how to handle Greg were much different.

On the next to last day of the Program group discussions seemed to be more relaxed and people were more willing to talk about their problems and plans. Perhaps this was due to a developing closeness and trust amongst members. This was at least how I was viewing the other group members by this time. Even Dwayne, who had remained fairly closed-mouthed during the entire Program, told us about losing his wife and children through booze, displaying

some emotion at this revelation. Other group members talked about their recovery plans: Ron and his wife would join a "couples" Alcoholics Anonymous group, if there was room in the group; Jack was convinced that positive thinking and a character change were needed, and he was prepared to work on these; Greg would go upstairs to the 28-Day Program if he was able to do so; and Dwayne would renew his association with Alcoholics Anonymous. These were among the enterprises each client would take on to attempt sobriety. None mentioned they would attempt social drinking.

The last meeting was begun by Barry who worked in psychiatry for fourteen years before coming to the Centre. He said he had been greatly influenced in his work by seeing numerous people with permanent brain damage due to alcohol abuse. His lecture on the medical aspects of alcohol and drug dependency was never given, due to a last-minute schedule change, but undoubtedly the views he expresses in his talk are influenced by his former work.

Little was said during this final group meeting. Dwayne was not present as he had apparently left the Centre at 10:15 a.m. to go back to work. It was explained that his boss had called him back to work earlier than planned. Jack and Ron both talked about having to change their characters to stay sober--and especially to maintain contented sobriety. Barry talked about shields that people use as emotional protectors. Barry brought up a point about

machismo and how male alcoholics must learn to communicate and allow their emotions to show. I asked him about women. Were they similar, in his viewpoint? He answered, "It's been my experience the ones I've seen tend to be 'strong types' who feel they have to keep the house going or whatever, and when they drink they don't let people know about it until they eventually collapse." These women, he says, "often end up with nervous breakdowns over at the [Hospital]" and "their husbands are usually the last to know."

There was a brief discussion of how people had changed during the program and commitment to recovery plans, and the 5-Day Program ended. Afterwards people hugged each other, gave each other addresses and phone numbers, wished each other luck and promised to keep in touch. There seemed to be excitement and relief, but also a sadness that the closeness amongst members was over--at least in its present form. I sensed the closeness of the group filled a loneliness in the lives of these men that would prove difficult to replace outside the walls of the Centre.

Evening Program Events

The "Family Program" is scheduled for Monday and Wednesday evenings. Clients in the 5-Day Program are expected to attend two evening films or lectures. This

activity is basically part of the 28-Day Program, although clients from other programs at the Centre also attend. Clients are encouraged to invite their families, or close friends, to these presentations. On Tuesday evenings there is an ex-client meeting, on Thursday night a "closed" Alcoholics Anonymous meeting and on Sunday night a public Alcoholics Anonymous meeting. Five-day Program clients are obliged to attend all of these events.

On the first family evening, a lecture was given by Steve, Co-ordinator of Industrial Programs for the Commission. He talks about working and alcoholism. What struck me most about his talk was his continual reference to alcoholism and rarely to other drug problems. This is no doubt due to the tremendous effect of alcoholism on industry, but since I knew several of the audience members were attending the Centre because of drug problems, I wondered if they felt somewhat ignored. I was reminded of Paulette's disclosure that in the last 5-day Program two group members had been disruptive and disgruntled to the point of leaving the Centre because they felt the program dealt mainly with alcoholism and gave little attention to their own drug problems.

On the second evening of the program there was an ex-client "Follow-up Society" meeting. This consists of a few former clients, who are still straight or sober, meeting with current clients. Most of these ex-clients

have been sober for less than two years, however, and they attend the meetings, as they candidly admit, mainly for themselves. That is, their presence at the Centre is a reminder of their continuing goal of sobriety and being with others, especially similar others, gives emotional support.

After the Follow-up Society meeting clients may attend a Narcotics Anonymous Meeting held in a church basement some miles from the Centre. These meetings are similar to Alcoholics Anonymous meetings except that they are for people with drug addictions, and meetings are "closed" in that they are not open to the public, except for one meeting per month designated as "open."

On Thursday evening there is a "closed" Alcoholics Anonymous Discussion Group. This type of meeting is closed to anyone not professing a problem with alcohol. I was not allowed, therefore, to attend these sessions, but clients told me these meetings could become quite intense and that unlike open meetings where particular speakers present talks, anyone in the group is free to discuss his or her problems and get group feedback.

On Sunday evening a public Alcoholics Anonymous Meeting is held. I attended several of these. Chairs are set up in a wide corridor on the third floor and Alcoholics Anonymous groups from around the metropolitan area take turns hosting the meetings. Clients at the Centre, ex-clients, and members of the hosting group--as well as other interested

parties such as myself, family members of clients, etc.--attend these Sunday evening sessions. At a typical meeting the philosophy of Alcoholics Anonymous is presented, an A.A. member reads "The Twelve Steps" to sobriety, and two speakers give personal, often emotional, testimonies concerning their deliverance from alcoholism due to A.A. membership. The "Serenity Prayer" is recited, as follows:

> God grant me the serenity
> To accept the things I cannot change
> Courage to change the things I can
> And wisdom to know the difference

The meeting comes to a close, and group members gather in the kitchen to drink coffee and chat.

To my knowledge, none of the clients in the 5-Day Program were accompanied by family members or friends during the evening events. The extent to which family members involve themselves in Centre activities varies. Some family members are seen daily at the Centre; other clients receive no visitors during their stays. There are many reasons for the latter: often clients come to the Centre from afar, family members wish to avoid being seen at the Centre or on Hospital grounds, or clients may be alienated from friends and family.

Films

The brochure states:

> Educational films will be used to focus on various concepts in drug dependency with the purpose of increasing patient awareness.

Films are shown daily at the Centre, and the 5-Day Program clients attend many of these. I will describe some of the films shown while I attended the 5-Day Program.

On the first afternoon of the 5-Day Program there was a showing of the film, "A Slight Drinking Problem." The film is about a woman and her drinking husband. The wife is constantly upset and nags her husband unremittingly about his drinking. She lies to his boss for him, makes excuses to friends, and generally tries to hide their problems from outsiders. The woman is in considerable distress over her husband's behavior and is on the verge of leaving him when she discovers Al-Anon, an off-shoot of Alcoholics Anonymous designed to help relatives to stop covering up for their alcoholic spouses, get their own lives in order and urge the alcoholic person to confront the destructiveness of his or her drinking without moralizing. In the film the wife learns to refuse to be ill-treated, to get on with her own life, lets her husband suffer the consequences of his behavior, and at the end of the movie even gets her husband to admit that perhaps he does have "a slight drinking problem"--which is meant to imply a step

in the right direction.

On the third day of the 5-Day Program there was another film entitled, "John is a Drunk. John is Sick." This is the story of a man who is hassled by everyone around him. Their message is essentially, "All you have to do is just quit drinking. That's all." It particularly emphasizes the public's misconceptions regarding the alcoholic and how their misunderstanding promotes continued drinking. One memorable scene in the film is when John's wife looks him in the eye, points an accusatory finger and proclaims, "You're a bum!" One day John collapses outside a bar and awakens to find himself in a hospital setting where he apparently undergoes some kind of long-term treatment. As his wife and family friend walk along to the hospital to pick up John on his release, they agree that, "John is sick." The story ends relatively happily with John accepting help from friends and family, and these associates accepting his condition as an illness. As the name of the film indicates, the sickness concept of alcoholism, rather than a moral concept, is promulgated.

Afterwards, group members commented on the movie. They thought it was good, and Jack even thought it was excellent. Comments made to me by Dave, one of the 28-Day clients, came to mind. Dave claimed that all or most of the films about alcoholism shown at the Centre stop just when they are getting started. He feels such films should

show what happens after treatment: How does the alcoholic maintain sobriety? How does sobriety affect the alcoholic's life? How do family members and friends cope with the individual's changed lifestyle?, etc. There did seem to me to be films shown at the Centre attempting to answer such questions. But Dave is unsatisfied with the type of film of which "John is a Drunk/ John is Sick" is representative. Differences in opinion as to whether this film was good or not perhaps reflect a difference in stages of sickness and recovery. Dave and Jack probably represent two ends of a continuum. Dave had been in treatment more than 54 times over the last 15 or so years, and has considered himself to be an alcoholic for years. Jack, on the other hand, is seeking treatment for the first time in his life, and has only just accepted the alcoholic label as applied to himself. It seems reasonable that Dave is more concerned with how to maintain sobriety after treatment as he has been markedly unsuccessful at this task, while Jack is still grappling with accepting himself as an alcoholic.

Another film shown during the 5-Day Program stresses medical aspects of alcoholism, i.e. dangers to health from alcohol abuse. The film presents facts and figures about the high proportion of drinkers who become alcoholics (approximately one in fifteen), accident and death rates associated with alcoholism, etc. The film's concluding remark is, "If the facts won't stop it, what will?" The

implication is that there is probably no better way of stopping alcoholism than by presenting facts to people. This brings up an interesting point, since much of the program (including other films) is rooted in emotional appeals for sobriety.

Recreation

The brochure states gymnasium and pool facilities of the Hospital "will be made available to patients who are able and will to participate in and benefit from them." While I was at the Centre, however, I learned clients were no longer able to use Hospital facilities. This was apparently due to the fact that Hospital facilities were merely rented by the Centre, and budgetary cuts had rendered it economically unfeasible to continue this practice.

Recreational facilities on the second floor include a games room and a T.V. lounge. Cards and other games are available and scheduled events occur, such as a monthly dance and open-air concerts on Hospital grounds. Twenty-eight Day Program clients also organized softball games which Detox and 5-Day Program clients could participate in if they so wished.

Relaxation Therapy

While I attended the 5-Day Program "Relaxation Therapy" consisted of relaxation tapes. Clients each took

a mat and followed relaxation instructions. These sessions lasted approximatley 45 minutes each, and must have been somewhat effective as several clients had to be woken up afterwards. My own reaction to these tapes varied; on the first morning as I listened to the tape I became very relaxed and nearly dozed off. On subsequent mornings, however, I could not fully relax and wished the session would end.

Meals and Breaks

All clients eat their meals at the Hospital cafeteria. They sit together, chat and get to know each other. Meals are generally an enjoyable part of the day. They also provide a change of scene from the Centre.

During meals and breaks clients often pair off and talk at length. I too took this opportunity to talk to clients about alcoholism and got to know several clients fairly well. They seemed quite willing to talk about their conceptions of alcoholism and problems associated with their drinking.

28-Day Short Term Treatment Program

Introduction

This section presents a view of the 28-Day Program. It differs slightly from the 5-Day Program in giving a composite picture of typical program events.

The Program is under the direction of a social worker and staff members include 5 counsellors and an occupational therapist. During the course of my fieldwork four students also attended Program events. These consisted of three social work students and a psychology student. A recently graduated M.D. also attended Program sessions as part of his post-graduate training in Family Practice. During the three months of fieldwork I met 66 clients taking the 28-Day Program. Every two weeks a new group begins. This will be either a large group of about 14 people or a smaller one of about six. The incoming group is called the 'new group' on arrival, and at this point the former new group is referred to as the 'old group.'

The 28-Day Program is given on the third floor of the Centre. Clients participate in program activities from Sunday night to Friday noon for four weeks. They leave the Centre on weekends, usually to go home, and are expected to complete an assignment during this period. Meals and "breaks" are generally spent together and clients are expected to participate in work therapy, creative therapy, group therapy, clergy discussions, follow-up society meetings, Alcoholics Anonymous meetings, attend lectures and films, relaxation therapy, be examined by a physician and engage in individual counselling.

Clients accepted into the Program must be alcohol and/or drug free for five days prior to admission. Staff

select clients on the basis of high motivational level and their assessed ability to benefit from the program. Other factors taken into account include family and work situations, severity of the problem, previous treatment experiences, and source of referral. Sometimes there are more eligible prospective clients than can be accomodated, while at other times staff have problems recruiting people and in contacting interested and available people on waiting lists.

Goals and Objectives

Appendix III presents the Resident's Handbook for the 28-Day Program. In this brochure staff write, "We consider our program to be mainly educational (p.1)." They further write, "The Staff of the [28-Day Program] share a common belief, in that drug dependency is a condition which is developed by excessive consumption or intake of a preferred drug to such an extent that drug consumption interferes with, and effects [sic] bodily and mental health, causes financial, social, family and employment problems but does make easy an already established life style." Program objectives are listed as follows:

(1) To interrupt the repetitive pattern of drug abuse.

(2) To provide information on the effects of alcohol and drug abuse as it affects him/herself, family, employer and close associates.

(3) To help him/herself to face reality.

(4) To develop a desire for personal achievement whereby he/she will improve his/her self-esteem.

(5) To develop a feeling of self-understanding.

(6) To aim at restoring physical, spiritual and emotional health.

(7) To offer acceptable alternate behaviors.

(8) To aim at restoring the resident to resume his/her role as a responsible individual in society.

(9) To assist the resident in making concrete follow-up plans.

What goes on

The Short Term Treatment Program takes place on the Centre's third floor, which is wholly devoted to this Program. Clients sometimes refer to the third floor as the 'penthouse,' to describe its top floor location, to distinguish it from the less pleasant second floor, and as a snide comment on its dissimilarity to a real, swanky penthouse. In contrast to the second floor, however, the third floor is neater, more spacious and brighter. There are fewer residents, and these clients generally seem more relaxed, happier and in better physical condition than those in Detox or in the 5-Day Program. One 28-Day client who had previously been in Detox told me, "You should be downstairs; that's where it's really at." By this he meant, Detox is where people are visibly suffering as they withdraw from alcohol, drugs or a combination of both.

Twenty-eight-Day clients have at least survived this initial period of suffering, and to many the second floor seems to represent pain and unpleasantness. Twice during my stay an ambulance raced with its siren blaring to the Centre's entrance. Twenty-eight day residents gathered and watched what was happening below from windows above, and speculated that some poor soul in Detox had D.T.'s, was in a coma, or had taken some kind of fit and was being rushed to the emergency ward of the nearby General Hospital. For many of the 28-Day clients I sensed Detox acted as an ever-present reminder of the pain they had managed to rise above, and as the hell they could easily slip back into.

The physical layout of the third floor is basically the same as the second. That is, there is a long, broad corridor which turns to the left for a short distance, then turns to the right continuing in another long, wide corridor similar to and parallel with the first. On this floor are offices, bedrooms, a kitchen, a large common room, a small lounge, a staff kitchen adjoining a visitor's room, a games room with a ping-pong table and craft tables, a small library and a creative therapy room. (See Appendix II, p. 165).

The atmosphere is relaxed, as on the second floor, and since participants in the Program are together for two to four weeks or more--depending on whether they start together and whether they have previously been in Detox or

the 5-Day Program together--almost everyone on the floor knows each other well. The atmosphere, then, is much like that in an office or other workplace, or perhaps a small school.

Schedule of Events and Content of the Program

Page 193 of Appendix III reproduces one of the several event schedules made up and distributed during my stay. Like the 5-Day Program schedule, the 28-Day schedules are flexible. For the first few days of the program, while clients are arriving, there is some confusion as to what events will occur at any particular time. This is especially true when a larger group is arriving, as each client has to be oriented, assigned a bedroom, etc. The schedule of events also is disrupted during the last week before a larger group leaves. This is because each client must undergo a 'roast' or 'hot seat'. Sometimes these roasts will go well over the alloted time for group therapy and special meal passes will have to be distributed and other events missed or rescheduled.

Components of the program are described below under headings comparable to those used to describe the 5-Day Program content. This structure is used because the 28-Day Resident's Handbook does not list categories of activities. It will, however, allow the reader to more easily compare and contrast the 5-Day and 28-Day Programs.

Atmosphere

Over the 28-Day period there are fluctuations in the atmosphere. For the first few days people are generally fairly quiet. Then, as they get used to the surroundings and the other people, things begin to liven up. There is a considerable amount of joking that goes on which often breaks what could otherwise be intensely serious. Staff sometimes get annoyed with particular clients or groups of clients for being too playful. Once the young M.D. made a remark on his first day in Group Therapy. He said, "What I see happening here is people cracking jokes just to diffuse things." He went on to admonish the clients for not taking 'group' seriously. Since his attachment to the group was new, this was an error on his part, and clients showed their resentment. A staff member backed him up, however, and told clients they should try to be more understanding when someone else was speaking and not needlessly disrupt things with jokes or talk almongst themselves while group was in session. But laughter was a big factor in the atmosphere of the program.

At other times, however, people were dead serious. As we will see, roasts in particular were occasions of intense emotional strain and clients sometimes even cried during these sessions. Bob's clergy groups and some of the films and other lectures also left clients visibly

moved. At the end of one of Bob's talks on love, guilt, loss and loneliness there was a stunned silence. Gradually all the clients got up and filed out of the room, shaking hands with Bob and thanking him for his words. Later they talked about the power of his lecture.

As the group members grow to know each other and have similar experiences over the period of their stay at the Centre, the members grow in closeness. One can feel closeness between members. For instance, in at least one session a man looked at another man and simply said, "I love you," without being laughed at or thought odd.

Education

As mentioned above, the 28-Day Program is considered by staff to be mainly educational. The Handbook specifies two educational foci of the program:

> (1) One focus will be on the individual as a person who had a drinking problem thereby leading to an attempt to teach the person about all aspects of alcoholism, e.g. its signs, symptoms, development and even more important by recovery [sic].
>
> (2) The other focus will be on the individual as a person and thereby deal with interpersonal relationships and effective ways of dealing with reality while enhancing

self-esteem, thus the purpose of group therapy.

These two aspects, again according to the Handbook, "will merge in the latter phase of the program."

In the Resident's Handbook under "Educational Inputs" the following are mentioned: films and lectures, group therapy, individual counselling and introduction to follow-up services. These program components will be discussed below under various headings.

Work Therapy

During the 28-Day Program each client is expected to carry out a small task daily such as cleaning ashtrays, keeping the kitchen tidy, taking out garbage, etc. Most residents carry out these jobs faithfully without complaint. Members of one group, amongst which there were several jokers, however, decided to redo the work list by changing names around and generally confusing clients. Staff were quite annoyed by this, and definitely did not find it amusing. Besides contributing to floor maintenance, work therapy is intended to foster a sense of responsibility. This is related to Program Objective 8 (See p. 182 of Handbook in Appendix III) which states: "Aim at restoring the resident to resume his/her role as a responsible individual in society."

Group Therapy

Group Therapy is generally held in the large, bright common room along the first corridor of the third floor. As the schedule indicates, a considerable amount of time is allotted for 'group'; some 10½ or more hours per week. It is also the focus of much interest and conversation.

Group is led by one of the counsellors, although usually more than one counsellor attends each session. The observed purposes of the therapy seem to be to encourage clients to 'open up' and talk about their problems, to confront clients with the "reality" of their situations, to promote self-understanding, and to provide clients with an accepting, caring support group.

In the first few sessions one of the counsellors gives a brief presentation on feelings and coping with loss, followed by discussion. During these first sessions clients are encouraged to talk about themselves, why they are at the Centre, how they came to be there, how they are feeling, etc. Weekend assignments are distributed on Fridays, and early the next week these assignments are discussed (See Appendix III).

In the third and fourth weeks of the program, hot seats and roasts begin. The procedure for these roasts changed over the three months of my fieldwork. The roasts were relatively tame during the first month. Each client was merely asked to look at and address the roastee and

tell how they perceived the person and their feelings about the person. This became superficial with clients saying something like, "Well, George, I think you're a nice guy, and I like you, and I wish you good luck when you leave here." Staff became annoyed with the lack of substance in such statements, particularly the absence of what they felt was constructive criticism, and instituted a new procedure for roasts.

After a few trial roasts during which there was much discussion among clients, staff members, and between clients and staff, a new procedure for roasts came into being. This was initially described and the roasts conducted by the head counsellor, Judy, using the new method. Another counsellor and one of the social work students, however, were decidedly against the intensity of the new roasts, and a perceived lack of training for and lack of understanding about the purpose of them. The counsellor refused to participate in or conduct any of the new roasts.

The method involved selecting a client to be roasted, having him or her write down in private four or five words to describe him or herself, then each other client wrote a word describing the roastee on a blackboard while the roastee was out of the room. On the roastee's return to the room, he or she selected each word from the board, asked whose word it was, and asked the other client to explain why

he or she had chosen such a description. The roastee could then agree or disagree with the description. After all the words had been dealt with, the roastee was asked to reveal his or her own self-description to see whether it accorded with the others. A counsellor, standing at the blackboard, or pacing back and forth in the middle of the group, directed the whole procedure.

As mentioned, these roasts could become quite intense. Insults and expressions of caring were passed between clients, or clients and staff members; some clients cried, others became obviously nervous; and clients not being roasted literally squirmed in their chairs with sympathy for the roastee. Afterwards, particularly if the client successfully opened up, he or she was hugged by staff members and other clients. On some occasions, however, staff members indicated their displeasure that a client had not opened up or been honest. After one roast Judy commented: "That was the biggest sham yet!" To which the client nonchalantly replied, "Everybody to his own opinion." After this particular roast there was discussion amongst clients about the sincerity of the client's conduct.

Roasts function to provide clients with feedback as to how they are perceived by other group members. This can be esteem-enhancing, or anxiety-arousing, or both. There is also an element of catharsis for those who open up, especially when the client expressed remorse for past wrongs.

Other clients participating in the roasts get an opportunity to express their opinions, share in the emotional happenings, and learn about others. While the roastee is recalling life events or problems, the other group members may think about and relate this information to their own problems. This was expressed cogently by one of the students who said she felt extremely guilty about thinking about her own problems while listening to other clients make their revelations. Like the other, I experienced this same sense of identifying with the roastee and relating my problems to theirs.

Clergy Group

On Tuesdays, Bob, the minister of the Baptist Church and a recovered alcoholic, comes to the Centre to talk with clients. He talks to the new group in the morning and the old group in the afternoon, for approximately one hour each.

Bob views people as composed of three dimensions: physical, emotional and spiritual. It is the latter of these three dimensions that the Clergy Group is designed to strengthen. The purpose of the Clergy Group seems to be to help people focus on the spiritual (and related emotional) aspects of their lives, as this is a facet of life which many alcoholics, and people in general in today's world, often ignore. In practice, both the emotional and

spiritual dimensions are addressed. Bob talks, for instance, about his suspicion that alcoholics have trouble dealing with loss, their inability to accept love from others, and the enormous load of guilt they are burdened with. One of Bob's favourite themes is "surrender" and he describes how this differs from defeat. He maintains that in order to attain "contented sobriety," one must come to grips with one's spiritual life which means recognizing and surrendering to a higher power, finding forgiveness from or in this power, and being guided by this power in daily living through prayer or meditation. Bob maintains there are as many definitions or conceptions of God as there are people. He says that anyone who has ever experienced love has felt God--because "God is love."

The Women's Group

The Women's Group is a relatively new addition to the Centre, only coming into being in the last few years. Its existence reflects a growing recognition of women's status in society, the special nature of female alcohol dependency--particularly with regard to family situation and problems of recovery--and the perceived need for female clients to be able to discuss their problems with other women in small, private groups. Female detox clients are allowed to attend if they so wish, and if their state of withdrawal permits attendance; 5-Day Program clients usually are encouraged to attend if they want to do so; but for women attending the 28-Day Program, attendance is mandatory. Outpatients also may attend if they

find the sessions beneficial, and students, with permission of all group members, may join in. Two counsellors conduct the meeting. It would appear that clients are either allowed, encouraged or required to attend on the basis of the perceived benefit to an individual's recovery. Accordingly, generally those clients who have received the most treatment are thought to be most able to handle the experience and profit from the group.

The rationale behind the group's existence is that women are thought to feel freer to discuss and gain insight into their problems in a comfortable, supportive atmosphere. I attended only one group session. On this occasion Peter directed the discussion, and laughingly remarked that one woman suspected he must be a homosexual because he leads a women's group. During the session Peter tried to get various women to open up and express their feelings. This 'worked' with some and two or three (there were about 10 present) began to cry at various points. Peter's message was that it was an act of trust and love, sharing, to open up to the group--and those that could not or would not were being needlessly afraid, cowardly, or selfish. He insisted that anyone could say, "Stop!" if he probed too deeply--which was quite true. However, individuals were pressured to do the "right thing," i.e. open up, and were rewarded with hugs for doing so. And for those who would not perhaps there were negative sanctions in being ignored, or withdrawal of affection. I had this feeling when I failed to respond openly to his questioning in this meeting.

Some timing conflicts remain with other Centre activities, but afternoon scheduling seems an attempt to find a convenient time for as many as possible. Nevertheless, commitment to female clients' special needs is still developing.

Evening Program Events

There are three types of evening events scheduled: the Family Program, Follow-Up Society and Alcoholics Anonymous/ Narcotics Anonymous. These are described below.

Family Program

On Monday and Wednesday evenings family members may join in Centre activities, which usually means attending a film or lecture. Staff encourages family members to become involved in clients' programs. Once a month there is also a dance which family may attend. And family members are encouraged to attend open Alcoholics Anonymous meetings and visit clients at the Centre at other times. Counsellors will often talk privately to family members when this seems desirable and it can be arranged.

Since some clients are living apart from and are alienated from family, and some have travelled considerable distances to attend the Centre, this is sometimes difficult to arrange. Further, some clients made comments like, "What's the use of talking to the rest of my family. They're all drunks too."

An attempt is made, however, to include family, sometimes friends and employer, in a client's recovery program. Films and lectures are presented on aspects of drug dependency, and one lecture is on human sexuality and communications. Afterwards family members stay for coffee or visit with clients elsewhere.

One of the students, a social work student formerly married to an alcoholic, gave a lecture as part of the family program in which she calls alcoholism a "family illness." In this talk she recounted how her behavior during marriage was almost as destructive as her husband's; she claimed that only through her association with Al-Anon was she able to recognize and deal with the situation. Another social work student mentioned she felt not enough emphasis was placed on trying to draw other members of the family into the treatment setting, and the unfortunateness of having to send clients back into family or other environmental situations that were detrimental to their recovery. As evidence of this she cited an 18-year old boy who was living with his 23-year old sister. It would seem as though their apartment was the scene of numerous alcohol- and drug-replete parties. So, although there is concern with individuals in their family or other settings, it appears that attempts to incorporate these elements into treatment meets with varying success.

Follow-up Society

Follow-up Society, as mentioned earlier, is attended by former clients of the Centre, usually people who have attended the 28-Day Program. Ex-clients meet with current clients, sitting around in a circle in the same common room

used for T.V. watching, group therapy, etc. Former clients dominate the proceedings as they have become, in a sense, experts on how to maintain sobriety, and models which other clients may emulate. Some of these ex-clients aspire to be counsellors at the Centre, and these meetings provide them with an opportunity to take on leadership roles. Counsellors, however, must have remained sober or drug free for two years after treatment before being hired as staff--or so said one ex-client who possibly aspired to a counselling job. This man was a former drug addict and came to the Centre in the evenings regularly to attend Follow-up Society Meetings, take clients to Narcotics Anonymous Meetings, informally talk to clients or staff, participate in dances. He also became involved in doing volunteer work at three local hospitals and set up a drug group which he said was, "designed to deal with the problems and growing pains encountered during recovery...living problems."

Follow-up Society seems to have a two-fold purpose: to introduce current clients to ex-clients who have managed to remain straight or sober and, secondly, to keep former clients in contact with the Centre. Ex-clients are tangible proof sobriety is possible. They are able to explain techniques they use for maintaining sobriety to current clients about to re-enter the outside world. Furthermore, by coming to the Centre, ex-clients may remain part of a peer group, enhance their self-esteem by assuming a kind of

expert role and by having an activity other than drug-taking or drinking to do for at least one evening per week. These group meetings are not attended by staff members, so clients are free to discuss topics of their choice, as they wish, without staff intervention.

Alcoholics Anonymous and Narcotics Anonymous Meetings

Alcoholics Anonymous (A.A.) and Narcotics Anonymous (N.A.) meetings are attended by clients during their stay at the Centre. Two A.A. meetings per week are held at the Centre (one open and one closed), and a N.A. meeting is held weekly in a church basement at some distance from the Centre. The organization and philosophy of both groups is similar, N.A. modelling itself after A.A.

A.A. and N.A. meetings are considered therapeutic. One purpose of requiring client participation is to encourage clients to establish or re-establish links with groups that may form an important part of post-Centre recovery. Response to these meetings, particularly A.A., varies. Some clients totally subscribe to A.A. principles, speak at meetings and participate during the Program and afterwards, while other clients attend reluctantly. One 28-Day client said of the meetings, "I don't get a damn thing out of them!" Others attend through compliance, curiosity, or determination to try anything to stay sober, and do seem to 'get something out of' the meetings. One 62 year old man who had recently lost his wife and was about to retire in three

months' time, attended an A.A. meeting a few hours after he had been roasted. Listening to an A.A. speaker discuss boredom and loneliness after retirement made him realize the new freedom of his retirement could also have negative effects and lead back to drinking and he had better think about ways to combat boredom, particularly loneliness. During his roast, however, this man claimed he preferred loneliness to dependence upon others. He said he was content to pay the price of loneliness for his freedom and independence.

Films

During the course of a 28-Day Program clients are exposed to numerous films--generally one or two per day. Films are shown in the lecture/film room on the second floor of the Centre, and video cassettes are screened on the television set in the common room. Films vary from those in which an individual or a panel of individuals discuss aspects of alcoholism in a matter of fact fashion to emotionally-charged dramas. One series of video cassettes are lectures given at a treatment centre in the United States. The series is based on Alcoholics Anonymous' "Twelve Steps." Another film features Dick Van Dyke, and another Carol Burnett. The majority of the films and cassettes deal only with alcoholism, but Dick Van Dyke's film deals with drugs as well, and the three-part produced-for-television movie, "You've Come a Long Way, Katie!", is the story of a television journalist who is addicted to alcohol and prescription drugs.

The intent of these films is to educate clients about various aspects of drug and alcohol dependency. But another function of the films is the elicitation of emotions. Through the films clients are reminded of their own lives and the pain they have caused themselves and others. After one dramatic film depicting a family trying to cope with a father's alcoholism, a client remarked to me, "That was just too close. Even the little girl's name was Debbie, just like my kid's." In "You've Come a Long Way, Katie!", the main character is followed through her initial recognition of alcohol and drug dependency, to treatment, relapse, and death. This seems to elicit client fears that they too will succumb to the same suicidal pattern. Although the intended purpose of the films is to educate clients about alcohol and drug dependency, the education received is not merely one of facts and figures. The films make clients vividly aware of the emotional turbulence alcoholism causes, and the less tangible aspects of the condition that are difficult to quantify or describe in objective scientific fashion.

Recreation

Once a month a dance is organized by the creative therapist. This is anticipated for several days prior to the event. Posters are prepared, clients are assigned tasks, such as making sandwiches, staff members and clients are asked to contribute food if they can (i.e., if they have a spouse who

can bake a cake, etc.), and many clients seem to look forward to the event with pleasure. It is talked about in group sessions; people are asked, for example, whether they have ever attended a party sober before, and how they will feel about dancing while sober. Other clients seem to be unmoved by the preparations, and some express disinterest, or even anxiety.

During the summer months (July and August) these dances are not held, but in the last group I attended, the clients themselves organized a party. It was replete with pop, food, music and dancing--and most people seemed to thoroughly enjoy themselves, despite a sex ratio difference--a definite lack of women--which was also evident at the other dances.

This last group also organized softball games. Patients from the psychiatric hospital and the second floor joined in. The games were fun to watch and to participate in. There was a range of skill displayed during these games: players included a one-armed, shaky man from Detox who looked like he could hardly see the ball, to rather physically fit young men in their twenties who could "knock it flying." There was a lot of banter and teasing throughout the games, and a lot of laughing.

During recreation and other times, humour played a large part in the proceedings. There seemed to be three fairly distinct foci of jokes: One concerned drinking and drug taking, another, mental patients, and another, aspects

of the healing process. An example of the first, is a client taking a line from a film, and applying it to a fellow client. Someone would point an accusing finger at a fellow client and cry, "You're a bum!" This particular line comes at a dramatic moment in the film, "John is a Drunk/John is Sick," prior to the "recognition" of John's sickness. Mental patients were the subject of many jokes. At various times one of the clients would begin exaggeratedly rocking back and forth imitating a particularly noticeable patient seen around the grounds and in the cafeteria, and lots of comments were made such as, "You shouldn't be in here, you should be in the nut house next door!" Aspects of the healing process were also the subject of jokes. A typical joking sequence centered around feelings. Counsellors in group therapy used a rather unique phraseology. If they wanted to know how someone was feeling, typically they might say, "And where are you at, Jim?" Ideally, Jim would respond that he was feeling sad, angry, nervous or whatever. Clients, during breaks and recreation periods, would often turn to each other, with, "And where are you at?" The response would be something like, "I'm right here in this chair!" or "I'm on a plane to Hawaii!"

Relaxation Therapy and Physical Exercise

For the first half of my stay at the Centre Yoga was given Monday to Thursday mornings from 8:45 a.m. until

about 9:30 a.m. This was given by a qualified Yoga instructor who came to the Centre for classes and left shortly afterwards. According to the instructor, the purpose of Yoga was multiple; to teach relaxation and to tone up muscles; to encourage clients to 'get in touch with their bodies'; and to encourage a sense of achievement, i.e., as positions could be held longer, etc. There were mixed reactions to Yoga. Some found it valuable and enjoyed it. One client enrolled in a Y.M.C.A. Yoga course taught by the same instructor on leaving the Program, and felt it was a major part of his recovery program. Other clients complained about how boring it was, how unnecessary, and how painful. During the sessions participation ranged from complete co-operation to joking around to walking out in complaint. While I was at the Centre the Yoga instructor decided not to continue coming to the Centre, at least for the summer. She told me, "I'm not doing this for money, and I'm fed up." Further, she noted she was "pissed off" with the attitudes of some of the clients, as it seemed almost impossible to instruct under disruptive conditions.

From the time of her departure until I left the Centre, about six weeks later, a variety of activities replaced Yoga. First, relaxation tapes were tried, but clients became bored with them. There were only a few tapes and these were used repeatedly. Then the creative therapist decided she could direct calisthenics for a few weeks. When she left on

holiday this job was taken over by particular clients. After the calisthenics clients were expected to go for a short jog or walk around the hospital grounds.

Creative Therapy

During the first week clients attend a Creative Therapy Orientation session. During this session the creative therapist describes and displays different craft projects, and asks clients to choose which project they wish to work on. Each client is expected to complete at least one project during hour-long daily sessions and during spare-time. Projects consist of rug hooking, string art, leather work, carpentry, etc.

The purpose of Creative Therapy is to foster a sense of achievement through completing a project and to introduce clients to a positive spare-time activity. One client who laboriously completed a leather hat seemed to undergo a personality change when the hat was finally finished. He wore it everywhere and was extremely proud of himself for seeing it through to completion. During the last week of a Program, clients would often ask me to come and see their projects or bring their handiwork around to show staff and anyone else who might not have seen it. One man told me that through working on his project he discovered the meaning of the Alcoholics Anonymous slogan, "Easy Does It!" He said he wanted to

rush through his project, but the therapist had convinced him to just do a little at a time and relax. He claims that learning to be patient and to work steadily without rushing were some of the most important lessons learned at the Centre.

The Physician

Once a week a physician comes to the Centre and gives clients physical examinations or talks to individuals about physical problems associated with their drinking. He also directs the use of Antabuse and Temposil. As part of the Evening Program, the physician also lectures on medical aspects of alcoholism.

Resident/Staff Meeting

Resident/Staff (R/S) meetings are held every Friday morning. They are generally brief and business-like. Staff members ask clients to recite Program rules, which are:

(1) No alcohol or drugs to be used while on the Program.

(2) No smoking in bedrooms.

(3) No sexual activity.

(4) Full participation in program events.

Any complaints are brought up either by staff members or clients. These complaints vary in their seriousness. For example, staff might chide clients about coming to the

Program events late. One of the clients might remind staff, however, that staff members often arrive late as well, and people will laugh. A serious complaint was brought up one morning that typifies the other end of the spectrum: A staff member said she had been informed that someone on the program was using drugs which, except in very unusual circumstances, would mean discharge. She asked the person to identify him or herself and take responsibility for the behavior. No one spoke up, and there was much discussion of the matter with various members expressing the opinion that the culprit should be identified by the staff member or informant and be immediately purged from the group. Finally one of the clients, after much debate interspersed with long silences, identified the accused, a 16-year old male client. He denied having taken any drugs, saying he had merely been "shootin' the shit" (i.e., bragging). With no proof and no confession, the boy was told not to "shoot any more shit."

During the R/S meeting staff might inquire how clients feel about leaving the Centre for the weekend. An answer to this query might involve a client mentioning he or she does not have a ride home, although this type of logistical problem is usually handled outside the meeting. Other clients express anxiety and reluctance to leave the Centre, while still others look forward to the weekend as an opportunity to see friends and family, etc. If not already done, weekend assignments are distributed at this time. Weekend passes

are also handed out.

The purpose of the R/S meetings, according to staff, is largely to keep communication lines open, particularly between clients and counsellors, as to how the program is progressing. It also functions to deal with problems relating to the Program and to last-minute details associated with weekend departure.

A further meeting function is to provide an opportunity for farewells. Staff wish clients luck, may thank them for being a 'good group' and remind them to keep in touch. The outgoing group will thank staff members and may even present them with a card and box of chocolates or a basket of fruit.

Meals and Breaks

Clients have their meals at the Central Service Building cafeteria, which is also used by Centre staff, and patients and staff of the Hospital. Clients identify themselves on entering the cafeteria, then proceed to gather their meal cafeteria-style.

Small groups of clients eat together. Only occasionally do they mingle with Hospital patients or patients from the Detox floor.

Mealtimes afford an opportunity for clients to relax, talk about the Program and get to know each other better.

Staff members eat their meals in the cafeteria also, but they eat in a section of the cafeteria partitioned off and marked "Staff Only." One Centre staff-member was critical of the division between staff and patients which he saw as perpetuating a non-egalitarian atmosphere and social stigma. On the days that he worked at the Centre he usually ate lunch with clients or hospital patients. Other staff members often encouraged me to eat lunch with them on the "Staff Only" side of the cafeteria. Although I did do this a few times, I always felt uneasy there. Staff members chided me about spending too much time with the clients, maintaining not only that I needed a break from them, but also they needed a break from me. This was not the impression I gained from clients, however, who invited me to sit with them, gave me salads, deserts, or beverages which they were able to obtain "free," knowing I had to pay for mine, and generally made me feel welcome. One client with whom I confided my feelings about the dislike of the partition did defend the separation though, saying "Well I suppose they sometimes want to discuss their work in private." On the last day of the 28-Day Program one small client group "celebrated" by sitting on the "Staff Only" side of the cafeteria, at a table just across the partition, partially hidden. A mother of one of the clients was present.

Apart from mealtimes, breaks between program events are short--from half an hour to perhaps one and a half hours.

Longer stretches of free time are available on evenings on which clients have no A.A. meetings to attend or after other evening program events.

During breaks and free time clients may rest in their bedrooms, play baseball or ping pong, work on craft projects, watch T.V. or sit in the kitchen talking and drinking coffee. Card games, such as crib, are often played at the kitchen tables as well. Occasionally a staff member will come into the kitchen to chat for a few minutes or perhaps even to have a cup of coffee or a quick snack, but the kitchen is largely the clients' domain.

Clients may also leave the grounds for walks, but if they intend to be away for long periods, they must get staff permission. While I was at the Centre clients were given permission to be away from the Centre to go to the beach, attend a movie, go to visit family and friends, and to keep job interview or other appointments.

Considerable time may also be spent in bedrooms resting. Some rooms are private, some semi-private and in some there are four beds. Free time allows clients to rest, which many seem to require as part of the withdrawal recovery process. Antabuse also produces a side effect of tiredness in some cases. Free time also gives clients time to think, time to analyze and re-evaluate their condition, and to digest information being given to them. During this period they may also make plans for their return to the

outside world. There is a pay phone on the floor, and clients can call friends and family, as well as answer advertisements in the newspapers for lodgings or jobs.

There was much talking done in pairs or small groups of clients, clients and counsellors, or clients and students, and, presumably, much of this is of a serious nature, since clients, staff and students make oblique references to personal information about each other that they have discovered during private talks. This seems to be part of the healing process; i.e., just "getting out" to another human being feelings associated with past wrongs or hurts, and past and current problems. Several times I was told by clients that what they were telling me about their personal lives had not previously been revealed to anyone else. During breaks and free time, then, besides engaging in recreational activities, the time is spent in self-reflection or self-revelation in small groups.

CHAPTER III

THE HEALING PROCESS AT THE CENTRE

Introduction

This chapter attempts to illuminate aspects of the healing process at the Centre. First it examines the nature of healing, some universal features of healing, and the healing process as a rite of passage. Then it examines cultural factors in the healing process, and finally there is a discussion of our culturally-specific approach to problem drinking. The term "healing" will be used to refer to the process of restoring an individual to health.

To some readers it may seem strange that treatment at the Centre is called a "healing" process. However, the treatment centre studied in this Thesis is located on hospital grounds, government medical insurance allows clients to attend free of charge, clients are issued plastic naming bracelets as are worn by hospital patients, and the programs promote sickness concepts. In the most recent edition of the Annual Report of the province's Commission on Drug Dependency available (Year ending December 31, 1979), the Chairman of the Commision writes: "It is hoped that, in the year ahead, facilities for the treatment and rehabilitation of alcoholics will command the same attention as do those required for other illnesses." Therefore, there is reason to term treatment at the Centre a healing process.

What is healing?

Just as medical anthropologists differentiate "disease" and "illness" (See Chapter 1), they often make a further distinction between "curing" and "healing." Such distinctions are not normally made by non-anthropologists who view such terms as synonymous. To anthropologists, however, "curing" refers to the process of alleviating biophysiological symptoms of disease and "healing" refers to the amelioration of subjective feelings of ill-health. Our Western medical system has been increasingly criticized for addressing the biophysiological aspects of sickness and neglecting psychosocial and cultural aspects of sickness that largely account for feelings of ill-health. That is, seeking cures, but neglecting healing. Separating "illness" and "disease," and "healing" and "curing," implies a sharp, but artificial division between mind and body. For heuristic purposes, however, these distinctions are justified as they permit attention to be focused upon those aspects of treatment which are least understood by researchers and practitioners, and of most interest to cultural anthropologists.

The following discussion, therefore, addresses the healing process rather than the curing process. When discussing healing, however, it is well to remember how little is understood of the process. Arthur Kleinman, a medically qualified anthropological "observer," writes:

> At the outset I draw attention to the inadequacy of our present understanding of the healing process. This is, in part, a function of the early stage we are at in medical anthropological research and theory. But it also results from an enormous distortion in clinical research and theory. For researchers in clinical medicine, healing is an embarrassing word. It exposes the archaic roots of medicine and psychiatry, roots usually buried under the biomedical science facade of modern health care. It suggests how little we really know about the most central function of clinical care. (1980:312)

The following sections attempt to uncover basic features of the healing process at the Centre. Since our knowledge of healing is limited, however, the Centre's healing process is discussed in rather general terms.

Kleinman (1980:311-374) describes "a social and cultural mechanism that appears to mediate healing" which involves providing the patient with "personally and socially meaningful explanatory models for sickness and its treatment." In some types of therapy ritual is involved in the operation of this mechanism. Kleinman writes of healing rituals as moving through three separate stages:

> The sickness is labelled with an appropriate and sanctioned cultural category. The label is ritually manipulated (culturally transformed). Finally, a new label (cured, well) is applied and sanctioned as a meaningful symbolic form that may be independent of behavioral or social change. (1980:372)

We can examine the healing process at the Centre as a ritual (in the broad sense of the term) to see if these three stages

occur, and the implications of this mechanism for treatment.

Although curing is largely accomplished in Detox, where withdrawal takes place, healing occurs throughout the programs. Clients are encouraged to label their condition and the label most often used is "alcoholic." Counsellors, narrators and actors in films, guest speakers, pamphlets, Alcoholics Anonymous members and clients themselves all use this label. Although one counsellor explicitly denied staff members ever label a person an alcoholic, saying instead that clients come to that decision themselves, others feel there is pressure on clients to admit to being alcoholics. I sensed this pressure as well, and one counsellor who complained to me about the liberalness with which the label is used, told me, "Detox is where people are rubber-stamped." At any rate, clients are labelled, or label themselves, with the term "alcoholic," and this naming of the condition may be thought of as a first step in the healing process.

In the next step the label is ritually manipulated and culturally transformed. Since the main thrust of the programs is toward defining the alcoholic as sick and non-culpable for incurring sickness (although accountable for maintaining sobriety), this seems the goal of the manipulation/transformation. During this phase, alcoholism receives a demythologizing and destigmatizing transformation similar to the process described by Gussow and Tracy (1968) in their study of a treatment process used in a leprosy

hospital. Myths about alcoholism are exploded; for example, clients are told that not all alcoholics are lower class people and that only a small proportion of alcoholics ever end up on Skid Row. They are also told alcoholics are not morally-weak, sinful drunks, just sick people, and medical and other evidence is presented in support of this contention. The film, "John is a Drunk/John is Sick," presents this process in dramatic form. In other words, the label "alcoholic" is ritually manipulated and transformed during the healing process so that the condition is classified and explained in less moralistic, less stigmatizing terms. Concurrently other components of the programs, such as the "brotherhood" amongst clients, and interest and caring by healers, reinforce this redefinition.

The final step is for a new label to be applied and sanctioned. But there seems to be no totally appropriate label to bestow upon the client. This is where the healing ritual and analogy has problems. Since alcoholism is considered a chronic condition with a high rate of relapse, the term "cured" and "well" are deemed inappropriate by Centre participants and society in general. One phrase commonly used is "recovering alcoholic." As some staff members point out, treatment is merely an initial step and at least two to five years are necessary before the condition may be considered arrested. One counsellor told 28-Day group members, "Alcoholism, like cancer, is arrestable, but

non-curable.", and the adage, "once an alcoholic, always an alcoholic" is promoted by some healers.

Levi-Strauss (1963) makes the point that healing is accomplished through the manipulation of symbols. In his discussion entitled, "The Effectiveness of Symbols," he describes how shamanistic healing and psychoanalytic healing derive their effectiveness through the creation of myth. Comaroff (1978:253) analyzing the Levi-Strauss material, concludes:

> ...Both the Western doctor and the shaman provide their patients with a fundamental therapeutic tool, namely a set of codes for ordering disrupted perceptions and for restoring the discontinuity between physical and social state, which is implied by illness. The way in which such codes are controlled may vary in significant respects between cultural contexts. But successful healers everywhere are engaged in precisely this operation; if any aspect of the healing process is universal, this is surely it. For, whatever their biomedical basis, diagnosis and therapy concern the interactive manipulation of symbols....

This seems to be the basic process occurring at the Centre. Cultural myths, or explanatory models, concerning the nature of alcoholism and reflecting society's beliefs and values, are created. These myths describe and explain alcoholism in less awesome and degrading terms, and clients are encouraged to subscribe to these explanations of their condition.

Another way of understanding the healing process is by conceptualizing it as analogous to a rite of passage in Van Gennep's terms. He characterized rites of passage--rites accompanying every change in place, state, social position and age--as displaying three phases: separation, margin (or limen), and aggregation (Turner 1972). Turner (1972:338-339) describes the three-phase ritual passage in the following quotation.

> The first phase of separation comprises symbolic behavior signifying the detachment of the individual or group either from an earlier fixed point in the social structure or a set of cultural conditions (a "stage"); during the intervening liminal period, the state of the ritual subject (the "passenger") is ambiguous: he passes through a realm that has few or none of the attributes of the past or coming state; in the third phase the passage is consummated. The ritual subject, individual or corporate, is in a stable state once more and, by virtue of this, has rights and obligations of a clearly defined and "structural" type, and is expected to behave in accordance with certain customary norms and ethical standards.

A thorough analysis of the symbolic dimensions of the passage at the Centre is beyond the scope of this Thesis. I do think it useful, however, to view treatment as analogous to a rite of passage with particular attention given to the liminal phase, because it illuminates aspects of the healing process.

The separation phase is perhaps most clearly played out in Detox. Clients arrived intoxicated, go through admission procedures which include signing forms, relinquishing

valuables (including alcohol which is disposed of), a mandatory shower, and issuance of required items and all clients at the Centre are separated from their usual environments. They are removed from a point in their social relations--which may include the state of being a "drunk"--and find themselves in an entirely new set of cultural conditions in which they discover concern, caring, and the need to submit to authority. They become "patients" or "clients."

The main feature of the liminal phase seems to be the ambiguous state of the ritual subject. He or she is betwixt and between. Turner maintains the passengers "are at once no longer classified and not yet classified" (1972:339). "Their condition is one of ambiguity and paradox, a confusion of all the customary categories (1972:340). At the Centre this condition of ambiguity applies to clients. Even though clients may have accepted an "alcoholic" label, they undoubtedly have been exposed to moralizing, often by significant others. In effect, they have been treated as "drunks" and at least partly have internalized this definition of themselves. Coming to the Centre they suddenly--perhaps for the first time in their lives--are treated as intelligent, cared-for, good individuals. It takes some time, however, before this message "sinks in" and is believed. Meanwhile they seem betwixt and between the former definition of themselves, and not yet fully convinced that a better redefinition is possible. They totter, therefore, between

being "drunks," "degenerate alcoholics," "sick alcoholics" and unstigmatized normal people with a "condition." In one group session a counsellor began a sentence with, "We're all human beings..." A client cut her off commenting loudly, "Are you sure about that?" This client, a man, was intelligent and very interested in philosophical matters. His comment, although taken by the group as an attempt at humour, revealed a concern for the underlying bases of the condition of humanness, and a questioning of whether "drunks" or "alcoholics" could perhaps in some sense be eliminated from the state of being human. Another client told me of an hallucination he experienced while under the influence of drugs in which his body was invaded by a being from outerspace who took control of his mind and body. He said that for months he believed everyone else on earth was human except him. He had become an alien. The point is that clients do seem to be in ambiguous states somewhere between stigmatized alcoholics or "drunks" and normal human status, and that this anomalous state receives the transitory label of "patient," "client" or "resident."

Turner (1972:338-339) maintains that during the liminal period the ritual subject passes through "a realm that has few or none of the attributes of the past or coming state." In this regard, the atmosphere and setting of the Centre are significant. It is difficult to present an adequate description of the atmosphere, particularly during

the 28-Day Program. I have briefly mentioned elsewhere in the Thesis aspects of this atmosphere. The overriding sense of concern, caring and acceptance of clients is paramount. There is a sharing and closeness that seems sincere and deep, and akin to love. Being at the Centre can be stimulating and fun; one's friends are there. There are people to talk with and things to do. Furthermore, the setting itself is special and removed from everyday experience, and may have no future parallel. People at the Centre talk about "outside" in contrast to "inside" the Centre, as if the Centre is conceptualized as an enclave somehow separate from "real life" outside. Prior to coming to the Centre clients are in a different, everyday kind of realm where they are subjected to negative sanctioning. At the Centre they take "time out" from this world, with ample time for self-reflection, pass through a different realm, and return again to the outside where not only is the setting different, but where the atmosphere and events are perhaps less stimulating and less comforting.

Ideally, again from the healers' perspective, the client emerges from his or her experience with a renewed sense of responsibility and perhaps a new self-concept. The client realizes what he or she must now do to remain sober or avoid drinking problems, has been given some tools for dealing with sobriety and to cope with life problems, has been exempted from a certain amount of blame, and has

been encouraged to assume a sense of accountability for his or her own actions. As the liminal period is completed, ideally the client moves toward a more stable state. He or she is no longer as confused about the nature of the condition, nor as confused about him or herself. Rights and obligations of the new state are made clear: the client is now aware that the condition is a kind of non-culpable disease or illness and is further aware of a responsibility to stay sober and take an active part in recovery--although this may be a life-long proposition. He or she is furthermore expected to resume behaving "in accordance with certain customary norms and ethical standards"--e.g., by resuming work, family relations, obeying the law, and the ethical standard of not hurting self or others through drinking.

In short, the healing process promotes a cognitive reorientation brought about through persuasion and the presentation of "facts"; a change in attitude and values; and, at least while at the Centre, a change in behavior. If the healing process at the Centre is successful, these changes will occur and be lasting. But clients experience no certain, complete break in status and this may detract from the success of the healing process. For, although clients have undergone treatment, they remain alcoholics.

Cultural Factors in the Treatment of Alcoholism

There are several ways in which culture affects the treatment of alcoholism or drinking problems. "Alcoholism" is a term for which there is no universally-recognized definition. What is labelled as alcoholism by one group of people may not be equivalent to what is called alcoholism by another cultural group--or, indeed, by members of another sub-culture within the same group. Furthermore, as Westermeyer (1981:45) points out:

> ...while there might be a widespread "etic" view that a particular group has a problem with alcoholism, the "emic" view may preclude the concept of alcoholism or assign other etiologies to the personal problems.

So, initially, a group must recognize alcoholism as a problem requiring treatment before such treatment is instituted (unless more powerful groups impose treatment upon others). Taking Newfoundland as an example, there seems to have been little recognition of health problems from alcohol until recently. Newfoundland is far behind other provinces in Canada in instituting treatment facilities for problem drinkers who have often sought treatment in other provinces. The situation has been particularly acute for female Newfoundlanders whom, it was thought, simply did not drink enough to experience drinking problems. A spokesman for the Alcohol and Drug Foundation of Newfoundland and Labrador told me that the main reason for a lack of

treatment facilities was due to the non-recognition of drinking problems. There has been a Newfoundland tradition of heavy drinking, and drinking was generally viewed by Newfoundlanders as a normal part of life. Furthermore, the provincial government failed to recognize or deny alcoholism was a problem until recently. As an example of growing discontent with government's attitude, one irate citizen who is President of the School Counsellors Association of Newfoundland and Labrador described the Newfoundland Liquor Corporation in the following letter sent to the St. John's newspaper:

> This agency of the crown (or jewel in the provincial treasury as I prefer to call it) is pushing and peddling alcohol like it was going out of style, with complete disregard to the perils of potential abuse, oblivious to the formula which states that the greater the sales the greater the abuse. The Corporation's Annual Report is a glowing testimony each year to their high-powered salesmanship. (The latest figures show an income of $52,000,000 with a total profit of almost $38,000,000.) (Condon 1981:6)

New statistics show a fairly dramatic increase from 1970 to 1978 in per capita consumption of alcoholic beverages in Newfoundland (Special Report on Alcohol Statistics, Health and Welfare Canada 1981:4) and problems associated with alcohol consumption, such as increased rates of liver cirrhosis (for males and females) between 1976 and 1978 (Ibid., 1981:19), and these data have been instrumental in

forcing the provincial government to finally recognize a problem. In 1982 the provincial legislature approved a bill to set up The Alcohol and Drug Dependency Commission of Newfoundland and Labrador.

Another way culture influences treatment is in the way the condition is classified. Is it a moral, spiritual, medical, criminal, social or legal concern? One staff member at the Centre said treatment was generally unacceptable and ineffective for local Native Indian people. He said that "taking the pledge"--or swearing before a priest to remain sober for a certain period of time--seemed to be more effective and acceptable. Although the Centre may not be acceptable to local Native people on many other grounds, that the two cultures seem to classify the problem in somewhat different terms--one medical and one spiritual--influences treatment.

An informative account of treatment of alcoholism (with "anomic depression") amongst the Salish Indians of British Columbia is given by Jilek (1981). In this account, anomic depression is described as a chronic dysphoric state developing "in reaction to alienation from aboriginal culture under Westernizing influences" and derived from experience of anomie, relative deprivation and cultural confusion (Ibid., 1981:161). Jilek writes:

> ...anomic depression in association with alcohol and drug abuse is today considered a major indication for spirit-dance initiation, especially when Western treatment modalities have failed, a conclusion drawn from discussions with Salish ritualists and from a review of the preinitation histories of some patients. (1981:163)

Spirit-dance initiation shows how alcoholism can be treated in a very different manner by a non-Western group. Jilek notes:

> Depatterning of the faulty alcoholic personality traits is achieved by suggestion, psychic and physiologic stress, in a regimen of sensory deprivation, alternating with sensory overload through kinetic, tactile, thermic and acoustic stimulations. (1981:163-164).

During this period the initiate enters an altered stated of consciousness, acquires his individual power, song and dance, "and in his first public dance feels blissfully carried away by his new 'Indian power'." This is followed by hardening physical training and intensive indoctrination designed to strengthen body and mind, and, finally, a new Indian identity is validated in a name-giving ceremony (1981:164). Jilek also discusses some similarities between Salish spirit-dance initiation and other Nativistic ceremonies and cult movements. One of his conclusions emphasizes the efficacy of such indigenous treatment approaches:

> Traditional or syncretistic cult movements of nativistic character, such as Peyotism and the recently received Sun Dance and Gourd Dance, have important features in common with Salish spirit dancing, including that of effective therapy for alcoholism. (1981:169)

This section is not intended to survey cross-cultural approaches to treatment of alcohol disorders. Rather its intent is to point out how alcoholism may be ignored, or may be viewed and treated as an entirely different kind of problem than so viewed and treated at the Centre. Newfoundlanders largely ignored alcoholism until recently. Salish conceptualization and treatment of alcoholism focuses upon the notion of loss and reinstatement of traditional tribal identity. Alcoholism appears to be viewed as a manifestation, perhaps a symptom, of the loss of Salish identity and through initiation rites an individual once again subscribes to tribal values and is re-assimilated into the society. The healing process in this context is concerned with social, cultural and spiritual aspects of the condition and not, as at the Centre, centrally concerned with other aspects described below. In the Salish case, alcoholism is viewed as a manifestation of anomie, relative deprivation and cultural confusion, and treated as such.

Through their comparative study of medical systems, medical anthropologists increasingly demonstrate that particular sickness episodes are interpreted as different kinds of problems in various cultures. Behavioral

non-conformity may be interpreted as mental illness, demonical possession, the result of sorcery, or other negative conditions, rewarded or ignored. Likewise, alcoholism is viewed and interpreted differently, depending on the cultural context in which it occurs, and treatment modalities vary accordingly.

The Centre's Healing Process as Culturally-Specific Treatment

This section identifies some important ways in which treatment at the Centre reflects and is shaped by culture. This involves examining how ideas about alcoholism relate to treatment. Glick (1967:32) decries the fact that in many ethnographies the relationship between ideas about illness and treatment are not clearly stated. He writes:

> ...although it seems reasonable to expect that responses to illness (treatments) would be the logical outcome of ideas about illness (diagnoses), it is not made apparent that ideas and actions are complementary facets of a cultural system. Treatments in particular are often presented as though they were a phenomenon unto themselves.

At the Centre ideas about alcoholism are related to treatment. These ideas about alcoholism may be subsumed under the label "diagnosis" which, following Glick (1967:35), is comprised of three dimensions: evidence, process and cause. Evidence is what we would call signs and symptoms of illness. Process is described by Glick as follows:

> Process, or what is actually happening to produce evidence of illness, is the focal concern in Western medicine. Pathology, the study of disease processes, is the foundation of our system of medical classification; illnesses are grouped together because they are understood to represent related pathological processes. (1967:35)

Glick claims that when practitioners in our Western medical system establish cause, this is a statement which becomes part of the diagnosis and supplementary to statements about process. For example, lobar pneumonia (process) will be described as being due to Diplococcus pneumonia (a bacterial cause). But he claims that in other medical systems there is more attention paid to socio-cultural context and ultimate causes--such as kinship and political relations, property and inheritance disputes, jealousy, envy, rancor, and spite (1967:37). He writes:

> In brief, whereas in Western medicine causation has no essential relationship to socio-cultural context, in most other medical systems causation and context are so intimately linked as to be the ethnographer's principal concern. Moreover, in the absence of understanding of disease processes, diagnosis may resolve into conclusions about causation inferred from evidence; that is, the dimension of process may be overlooked altogether, or it may be relegated to strictly secondary significance (1967:36).

At the Centre the main view of alcoholism promulgated is that of a primary, progressive, incurable sickness--a chronic or long-term condition requiring abstinence. First

of all, excessive drinking is recognized as a problem requiring treatment; it is not ignored, nor viewed as an eccentricity or even a normal response to some cultural contexts. Next, a variety of individuals with an array of problems are subsumed under the label, "alcoholic" or perhaps "drug dependent." The condition is called primary--not the result of other diseases or sicknesses, environmental pressures, demonical possession, or any other known causes. Excessive drinking is said to be sufficient in itself to cause alcoholism. There is also no recognition that the condition need not progress over time. Clark and Cahalan (1976:183) discuss their findings of a longitudinal study, noting:

> Drinking problems do not typically appear to be unilinear, with progression from less severe to more severe problems and from single problems to many problems... Many drinkers with numerous and severe problems are found to have gotten out of trouble at a later time. These findings are in keeping with recent findings that it is among young males rather than older men that the highest rates of almost all types of drinking problems are to be found.

Alcoholism is also conceptualized as incurable, and a return to social drinking is considered impossible as a treatment goal. This, however, is a highly controversial issue. Compare, for instance, the counsellors' encouragement of abstinence with the following statement: "In a given case, abstinence may be neither a necessary nor a desirable goal in terms of drinking outcome" (Rattison, Sobell & Sobell

1977:200). As shown later in Chapter IV, a part-time counsellor also challenges the predominant notion of abstinence as the only possible treatment goal.

At the Centre there is also a kind of "mental health" view of alcoholism emphasized. There are films and talks about emotions and their role in communication and interactions, group therapy, group discussions and roasts. Alcohol is said to distort emotions and cognition--sometimes permanently in the form of brain damage--and the alcoholic lives in a world of denial and distorted reality. The process of becoming an alcoholic is generally described in terms of gradual erosion of mental functioning through an inexorable series of stages. There is little in depth discussion of how psychological processes, alone or in conjunction with other factors, account for the development of alcoholism.

Physical and spiritual aspects of alcoholism are also addressed, and the emphasis seems to be upon what continued excessive drinking leads to--such as physical dependency, intolerance, liver cirrhosis, etc., and guilt, loss of faith, discontentment, etc. There is no extensive examination of physical susceptibilities or spiritual problems that may pre-date and, in a sense, "cause" alcoholism.

In short, alcoholism at the Centre is diagnosed by reference to evidence of behavioral, physical, emotional, spiritual and social signs and symptoms; process, which

involves describing the results of excessive drinking and the gradual development of these problems; and cause which is basically drinking per se.

Treatment at the Centre does not particularly dwell upon, or minutely examine, underlying processes which may cause or underlie the pathological process. Nor does it show how these processes relate to ultimate socio-cultural causes.

Strug (1981:207-216) makes the point in writing about a 28-Day Treatment Program in Seattle, Washington, that psychological and social aspects of the condition are under-emphasized. He sees both positive and negative consequences of treatment. As an example of the positive consequences of treatment, Strug claims, "Treatment provides him [the client] with a personally acceptable explanation of why he drinks," i.e., he has a sickness. On the negative side, however, Strug argues that, "treatment fails to create in the mind of the resident an understanding of the possible relationship of his drinking to sources of stress in his environment which may be associated with his drinking" (1981:213). He further states that psychological factors associated with drinking are under-emphasized:

> Counsellors consider the resident too "toxic" at this state of his recovery for psychotherapy to be used as part of the recovery procedure. Therefore, "group therapy" is not so much a dynamic process of examining psychological

> factors involved in drinking as it is a rather straightforward exchange of facts about events in the life of residents for 5 days a week (1981:214).

He notes that individual counselling similarly tends to avoid probing and confronting.

At the Centre described in this Thesis, certainly psychological factors are taken into consideration--and even over-emphasized compared with healing processes in other cultures. Kleinman (1980:159) notes - for example, that cases of psychological disorder in Taiwan are frequently treated by medical practitioners rather than psychiatrists because many patients tend to somatize their conditions. He defines "somatization" as "the substitution of somatic preoccupation for dysphoric affect in the form of complaints of physical symptoms and even illness" (Ibid., 1980:149). He writes:

> Since psychological disorders among Chinese, such as the cases of depression described above, fit better into the somatic treatment orientation of Western-style and Chinese-style medical practice than into the psychotherapeutic orientation of psychiatry, it is not surprising that we find psychiatric practice with Chinese patients frequently following a medical rather than a psychotherapeutic treatment approach (Ibid., 1980:159).

At the Centre, rather than emphasize the physiological or somatic aspects of alcoholism, more often psychological aspects are focused upon.

With regard to social or socio-cultural factors influencing alcoholism, the Centre deemphasizes these factors, similar to what Strug found in his Seattle study. In particular, psychological proceses are not viewed in sociocultural contexts. Drinking is generally depicted in negative terms, and there is little recognition and discussion of the positive aspects of drinking. Strug (1981:214) makes the point that, when excessive drinking is viewed outside its environmental context, it loses some of its reason for being. Westermeyer (1981:49), in discussing post-treatment anomie and what he refers to as the "drinking problem syndrome," states:

> As people with DPS attempt to become abstinent, they must alter or abandon many well-established, alcohol-related values, behaviors and affiliations--perhaps even an egosyntonic identity as a "drinker" or a "drunk."

At the Centre drinking is also mainly viewed negatively and the emphasis is upon drinking as an inappropriate and destructive coping strategy.

Furthermore, social or sociocultural stresses are under-emphasized in that how environmental stresses may provoke alcoholism is left largely unexamined. There is little systematic discussion of either drinking patterns in our society or risk factors associated with alcoholism, such as age, sex, occupation, poverty, ethnic affiliation, race, class, geographical location, etc. Rather, the emphasis is

on alcoholism as a sickness which anyone can develop. Thus the Treatment Co-ordinator's statement, "The only thing alcoholics have in common is repeated use" ignores that some people are more at risk in developing the condition than others.

In short, treatment at the Centre focuses on an individual, sickness concept of alcoholism, without fully explicating underlying psychological, biological or "spiritual" processes, and without fully relating these to sociocultural context. In effect, treatment at the Centre, by calling alcoholism a sickness whose locus lies within the individual, fails to bridge the gap between physical and psychological state and society, and fails to mend the disrupted relationship. And, as Gordon reminds us,

> Millions of people are addicted--to barbiturates, heroin, methadone, and alcohol.... Too often we forget that these problems have their roots in the particular conditions of our society, that any attempts to achieve "mental health" must be inseparable from efforts to create a just, decent, and personally fulfilling society (1979:411).

Conclusion

This chapter discusses aspects of the healing process at the Centre. It examines the nature of healing, universal features of healing, the healing process as a rite of passage, and cultural features of the process.

Healing is seen to involve the alleviation of feelings of ill-health which derive from a disruption between the physical or psychological state of the individual and society. Healing focuses upon mending disruption by manipulating perceptions and creating a myth which explains the illness episode. The healing process may be envisioned as analogous to a rite of passage by which sick individuals are reincorporated into stable states within society. Treatment at the Centre is influenced by cultural perceptions which focus attention on the individual as sick, and therefore unable to adapt his or her behavior to social or environmental conditions. The healing process at the Centre attempts to strengthen the individual, rather than modify environmental conditions contributing to or producing the condition.

Chapter IV immediately following now examines in greater detail client and healer conceptions of alcoholism and treatment as played out at the Centre.

CHAPTER IV

CLIENTS AND HEALERS: CONCEPTIONS OF ALCOHOLISM

Introduction

This chapter describes clients and healers at the Centre and their views on alcoholism. In gathering the information basic to this chapter, an attempt was made to be as unobtrusive as possible. I chatted informally with participants at the Centre, conducted informal interviews and observed interaction among participants. There was no attempt to gather such quantitative data as might be obtained from questionnaires. Rather, I attempted to gain acceptance from both client and healer groups and discover their ideas through "natural" interaction. The implicit assumption is that use of more formal techniques would have yielded less candid or "true" data. Although they might appear more "systematic" and permit quantification, they would not be closer to what Centre actors actually say and think when interacting.

Use of the tape recorder, and even note-taking, was looked upon with suspicion by some informants, and was impossible in most situations. Therefore, I used the tape recorder infrequently and often wrote up my notes in the privacy of my office or "at home" at the Nurses' Residence.

After describing clients and healers and their ideas, a brief discussion of this material follows.

The Clients

The clients (also known as "patients," and sometimes as "residents") are ordinary-looking people apart from the expressions on some of their faces, particularly if they are new clients. In their expressions I sensed shame, guilt, fear, anger and that many of them wished to remain somehow unseen. After a few days at the Centre, however, clients tend to relax, perhaps recognizing that within the confines of the institution they will be more accepted and cared for than they would be outside its walls. Part of this tendency to relax is, in some cases, also an effect of the withdrawal process. Withdrawal from alcohol in those who are physically dependent may be accompanied by a number of symptoms. Early symptoms include "the shakes" and "consist of a tremor, general nervousness and anxiety" (Swinson and Eaves 1978:134).

As clients get to know each other, particularly during the 28-Day Program, there evolves a closeness amongst group members that is typical of close friends. There are, however, divisions between the clients between "old group members" (i.e., those that have been on the program for two weeks prior to the arrival of new clients), and "new group members." Another prominent distinction is that between drug addicts and alcoholics. Although some

clients have "cross-addictions" to alcohol and prescription drugs, clients who are addicted to "street drugs" seem to maintain a separate identity. They talk about "flashbacks" and "cravings" and the difficulties of keeping away from drugs. In one group discussion, a young female drug addict talked about her cravings and suggested a contrast with craving for alcohol. She said, "With me it's more a physical thing. I get quite violent." Also, there is some feeling of distance between older group members and younger clients. Older clients, in their fifties and sixties tended to congregate together, and teenage clients did likewise. It did not appear to me, however, that sex, occupation, educational level or ethnicity divided people.

Staff Conceptions of Clients

Staff members point out that clients come to the Centre from every walk of life. This, however, is an idealized version of reality. Client characteristics are described below; the very rich, famous, the professionals, some Skid Row "repeaters" and certain ethnic group members are either excluded or exclude themselves from receiving treatment at the Centre. Although the Detoxification Unit is supposed to be open to all who need the facility, one Detox attendant told me, "The Centre has clamped down on taking in Skid Row bums because they just use the place as a flop." From what I could ascertain, all people are

accepted in Detox if they meet the admission requirements of being intoxicated, ambulatory and co-operative, but if beds are not available then repeaters may have to be turned down or wait for admission. With regard to the 5-Day Program and the 28-Day Program, (and particularly the latter,) staff are more selective. Clients are chosen for these programs on the basis of high motivational level and the likelihood of their benefiting from the programs. Selection criteria are outlined in Appendix III (pp. 169-171; p. 193).

Sex

The majority of clients are male. The Annual Report of the Commission on Drug Dependency for the province in which the study was carried out publishes selected client characteristics annually. For the year ended December 31, 1979, the statistics presented for all facilities in the region indicated that approximately 80% of the clientele were male, 13% were female and on 7% no data were available. Of the 71 clients attending the 5-Day and 28-Day Programs while I conducted fieldwork at the Centre, 57 were male and 14 were female. This works out to approximately 89% male and 20% female--or a 4:1 male/female ratio. This is consistent with findings that men outnumber women in alcoholism treatment agencies in all Canadian provinces. The percentages vary regionally, however: in the Prairie provinces almost 30% of the cases were female and in the Atlantic provinces only about 15% of cases were female in

1976 (Statistics Canada 1981:29).

The percentage of women in treatment, however, should not be confused with the estimated number of female alcoholics in a population. The Centre's Director estimated that there is a 1:1 ratio of male/female alcoholics in the region. It is difficult to estimate the number of alcoholics in any population, due mainly to denial and concealment, much less to determine the number of male to female alcoholics. A more conservative estimate of male to female alcoholics in Canada as a whole is 6:1 (de Lint 1976:332).

Age

The clients I talked to in the 5-Day and the 28-Day Programs ranged in age from 16 to 72 years. Both of these extremes were clients who were there for alcohol-related problems. The following table summarizes the age groups of the clients by sex:

Age	Females	Males
Under 20	1	4
20 - 29	4	16
30 - 39	4	16
40 - 49	3	14
50 - 59	1	3
60 years +	1	4
	14	57

Occupation and Labour Force Participation

Less than half the clients attending the programs I participated in were employed in full-time jobs. The remaining clients were only employed part-time, were retired, handicapped, in jail or unemployed.

Below are the figures for client labour force participation:

	N	%
Employed - full-time	29	41.4
- part-time	3	4.3
Retired/disabled	7	10.0
Unemployed	27	38.6
Other	5	5.7
	71	100.0

These figures assess labour force participation at the start of each client's program. Some of the clients obtained jobs during the course of their programs, or upon completion of their programs, and at least two clients became unemployed during their stay at the Centre.

People in the programs were or had been mainly employed in unskilled or technical jobs. These people were dockyard workers, waiters, cooks, clerks, taxi-drivers, fishermen, mechanics, technicians, etc. Many of the men had been in the armed services (which is expectable given that the metropolitan region is a centre of naval activity). Two

clients were employed as teachers, and one client was a former teacher. Three clients held government administrative positions, and at least two of the clients were self-employed.

Education

Most clients I talked to had some high school education, although many had not completed high school and at least three were illiterate. Several clients had some post-secondary technical college or university education.

Residence

All but two of the clients were presently residing in the province in which the study was conducted. These people lived mainly within the region serviced by the Centre. One man was residing in Labrador and another in the Caribbean; both had travelled to the Centre to take the 28-Day Program.

Ethnicity

The vast majority of clients were born in Canada and all but three of these clients were white. Two exceptions were black Canadian-born males; the third, a man from India. I was also told that one of the teenage males who left the program after a week or so was part native Indian. The boy never mentioned this to me, and there was nothing in his appearance to suggest this ethnic affiliation.

To my knowledge, only six of the clients were from outside Canada. One man had travelled from his home in Bermuda to take the 28-Day Program. The other five people had resided in Canada for some years prior to coming to the Centre. One man was from Norway, one from India, one from Wales, a woman from Holland and another woman from Germany. All of these people had been in Canada for some years, and all spoke excellent English.

Other Client Characteristics

Looking back at my fieldwork at the Centre, I cannot honestly think of a single client I did not like. It is difficult to judge whether these men and women were in some ways more understanding and likable (at least when sober) than people who had never had alcohol or drug problems. I also suspect the atmosphere at the Centre had a lot to do with my perceptions. Not only did people live together there over a considerable time span, but part of the healing process was to create an atmosphere of love and understanding, and in such an atmosphere people become very sensitive to each others' feelings. Honesty was also stressed by both healers and clients and people seemed to be relaxed enough to be "themselves" once they had become used to the place. This, however, was a difficult task for some individuals who took a long time to become less self-conscious.

Individuals could be placed along a continuum in terms of their friendliness and extroversion. Some clients were talkative and open from the time of their arrival at the Centre. Others gradually developed an easy manner as the program progressed. Group therapy sessions, and particularly the "hot seats" or "roasts" (to be described later), were instrumental in getting clients to "open up" and interact with each other. Unfortunately, roasts were often conducted late in the programs so that some of the quieter clients

only opened up in their remaining few days at the Centre.

Humor played a large part in client interaction. There were particular clients who could always be counted upon to enliven the group with joking around. For example, one client came to his roast in a huge roasting pan in which he sat, in the middle of the room, for about 1½ hours.

But there were also many serious times. One image of the alcoholic that was commented upon in films and by clients themselves was the "Jeckyll and Hyde" nature of the "alcoholic personality." Another was the image of the alcoholic or addict as a "con artist." In one of the group sessions a young drug addict was being praised on aspects of his character. He replied, "Yeah, but you guys just see me in here. If I was back on drugs and needed a fix, I'd use every one of you in this room if I had to." One of the alcoholics added, "All of us would do the same thing too."

Client Conceptions of Alcoholism

In this section clients' views on alcoholism will be presented. In particular, I attempted to discover what clients felt comprised the essence of the condition (i.e., the definition); what kind of condition they felt alcoholism was (i.e., the classification); plus their conceptions of causation and treatment.

During this discussion it should be remembered that clients coming to the Centre are at various stages of their struggle to cope with alcohol or drug problems. Some have been exposed to treatment of one sort or another--often over many years. For others this is their first attempt at receiving help. As has been shown here, clients are a heterogenous group. Where experts have basic disagreements about the nature of alcoholism, one would expect a variety of opinions about alcoholism in a heterogeneous client group. This expectation is largely fulfilled.

Alcoholism Defined

Clients could not articulate or did not know what the term alcoholism meant to them, or exactly what an alcoholic is--and this is despite the educational intent of the program. I attempted to talk to individuals as early on in their programs as possible, but sometimes I was unable to talk to a client alone--mainly because of time constraints--until after he or she had been exposed to the programs for several days. I asked clients what the term "alcoholism" meant to them, and how they could tell an alcoholic from a non-alcoholic. One informant claimed alcoholism is "a condition involving loss of physical and emotional control which leads to dependence." Beyond this, he seemed unable to specify what he meant by "loss of physical and emotional control." This kind of ambiguity

typified responses.

Coupled with this inability to define the term "alcoholism" many clients expressed uncertainty as to whether or not they were alcoholics. To the question, "Do you consider yourself to be an alcoholic?", one client answered, "Yes...Well, no...but I have problems with its [alcohol's] use." Another man told me he wasn't sure he was an alcoholic. Then he said, "Yes, I am an alcoholic, but a different kind of alcoholic: I go on binges." He also claimed that he "wasn't a bad alcoholic," i.e., not a Skid Row bum. One client said he preferred the term "problem drinker" to alcoholic, as the latter connoted the image of the Skid Row bum.

Many clients, however, admit to being alcoholics--sometimes with great difficulty--but often nonchalantly or even emphatically. One client I spoke with told me of the difficulty of accepting the alcoholism label some three weeks prior to my interview with him. He said it was one of the most difficult things he had ever done, commenting: "Those other guys were alcoholics, but not me!" When asked if he thought he was an alcoholic, one informant quickly said: I don't think I'm an alcoholic, I know I am!" So there is a wide range of degrees of acceptance of the label, perhaps at least partly reflecting the lack of

clarity in defining the term.

Quite often when I asked an informant what the term "alcoholism" meant or whether they could define the term, they answered that it was a particular kind of condition. In other words, they did not distinguish between what comprised the essence of the condition and how they would classify it. The following example of an answer to the question, "How would you define alcoholism?" is illustrative: "I would define it as a disease, a very progressive disease." They were, in fact, answering another question: "What kind of condition is alcoholism?" or "How would you classify alcoholism?" I had thought that since clients were personally involved with alcoholism they would be able to provide cogent definitions of the condition, but instead they were better able to describe the classes of phenomena into which alcoholism could be placed.

Classification of Alcoholism

The main classification of alcoholism promoted by the Centre is a medical one, although this is not exclusively promulgated. Alcoholics Anonymous has always adhered to an illness concept and many clients have or have had contact with Alcoholics Anonymous. Their families may also have had contact with Al-Anon where the sickness concept is also promulgated. An Al-Anon brochure states, for example:

> ...alcoholism is an illness. The wife is no more responsible for alcoholism than she would be for the existence of diabetes or tuberculosis in her husband...However, by lack of knowledge she may allow the illness to go unnoticed.

It is not surprising, therefore, that a number of clients subscribe to a disease or illness concept of alcoholism. One man I talked with said he "grew to believe" while in the program that alcoholism is a disease. He said, "I never knew that before." When I told him that some people objected to calling it a disease, his reply was, "Well, then they don't know what they're talk'n about." A female client, a member of Alcoholics Anonymous, shows evidence of accepting the idea that alcoholics are allergic to alcohol--one of the ideas promoted by Alcoholics Anonymous. She told me:

> Well, I don't really think about it as a disease. But it is a sickness. Like this... say the doctor told me I was allergic to ice cream, then I wouldn't eat ice cream because it would make me sick, but if the doctor told me I was allergic to alcohol, I probably wouldn't just stop drinking.

The most emphatic answer I received to my queries here was given to me almost angrily as follows: "Of course it's a disease! Do you think I want to be like this?" Another man whom I will call Dave has been in and out of Detox for years and was presently enrolled in the 28-Day Program. He seemed to subscribe wholeheartedly to the disease concept. He said:

> Alcoholism, to me, through my own experience, ...it, it is a disease, an illness, or whatever, but it is a medical thing. And it's not only physical...Your most physical aspects of drinking to me, would be when you stop drinking and start your withdrawal. It's caused, with me...it's caused stomach problems...I've had to be operated on...And it's affected my nerves terribly. I started developing a very severe anxiety state...

The logic behind Dave's acceptance of the disease concept is readily understandable given his very real medical problems, and similar reasons may at least partially motivate other clients to accept the concept. But one staff member argued that Dave had put his family "through hell" over the past several years and Dave readily admitted that he used the disease idea to both salve his conscience and to continue drinking over the years, i.e., he couldn't help himself if it was a disease. Further, one day I found him in the corridor agitated and excited about the fact that his insurance claim for wages lost during treatment was being denied because his insurance company did not recognize alcoholism as a medical condition for which compensation was due (although a few days later they did accept his claim). He also told me that people who had been discharged from the armed services "on account of booze," as he had been some years previously, should be compensated for losing their jobs and pensions. He said he hoped my Thesis would be instrumental in persuading government and other agencies to recognize alcoholism as a

medical condition.

Dave's wife has been a member of Al-Anon for several years, and Dave claims that if it were not for Al-Anon their marriage would have ended some time ago. Spouses's attitudes may be important in the acceptance or rejection of a sickness concept. Other clients pointed out the lack of support given by spouses. A typical statement made by clients was, "My wife just doesn't understand." Many clients, then, bring with them to the Centre feelings of guilt and misunderstanding stemming from chastisement from family members. They bring with them a feeling of alcoholism as a moral problem, a feeling that their characters are somehow defective.

Some clients express uncertainty or denial of the disease concept. Bill, for example, said he did not know whether alcoholism is a disease or not. He claimed that his personal problems stemmed from "social stress" more than anything else, noting he just gets shaky around stressful situations such as his arguing neighbours. Another client felt that alcoholism was basically a social problem but that a family doctor should be approached for the condition. He noted that although mainly a "social problem, it is also a disease" and should be treated as a "medical problem." Ed believed that alcoholism is a habit, not a disease, and compared it with smoking or taking drugs. He felt that it was mainly a character flaw, quickly adding "or that's how

it's thought of."

In one of the clergy groups, the clergyman asked: "Well, what kind of a condition do you think alcoholism is? Is it a physical, mental or spiritual problem?"--the clergyman thus providing the categories. In response, one client claimed it was physical, because alcohol is a chemical. Others said they didn't know. Many remained silent, and others agreed it was "basically psychological," especially after withdrawal and sobriety. None of the clients mentioned the spiritual aspects of the disease. The cleric, however, espoused the idea that alcoholism was a physical, mental and spiritual problem.

Jack, one of the men in the 5-Day Program, expressed the view that alcoholism involved one's whole orientation to life:

> Alcoholism is a disease that can't be cured, at least medically. However, I think that it can be suppressed by changing your attitude to life itself.

What this man seemed to feel was that one had to undergo a complete character change--a notion promoted by a staff member who gave a talk in the 5-Day Program--almost a rebirth, adjusting one's entire stance towards life. He told me he was not a religious man, but was searching for something. He said he had recently begun listening to taped lectures on positive thinking. He had purchased these tapes through a magazine, in hope of developing a better attitude

towards life. He also asked me if I had ever really looked at a tree. He said that he had been sitting outside the previous evening and had really taken a good look at a tree while thinking to himself, "Something must have put it there." The impression this man gave was that, although his classification of alcoholism was basically medical, it also had a spiritual or existential dimension. Recovery meant a character or spiritual change brought about by a more positive attitude towards existence.

Causes of Alcoholism

Some informants stressed biological causes of alcoholism. One informant told me he felt alcoholics and drug addicts were "born with a sensitivity or weakness." This was viewed as a physiological sensitivity or weakness rendering a person susceptible to developing drinking or drug problems. This same man, however, felt family upbringing and morals play a part in whether one becomes drug dependent or not.

Some clients stressed the psychological predisposition of the alcoholic. For example, George, a very large man in his forties, told me that in his case he was a fat child and kids teased him so he began hiding his true feelings. He continued to do so into his adult years and said that, until recently, he was immature. He believed that becoming an alcoholic was "the result of my immaturity...I didn't

give a damn about anything." Such clients tend to view psychological problems as predating their alcoholism in contrast to those, like Dave (quoted on page 136) who denies he had any psychological problems until he began drinking heavily. One young man of about 20 years old was upset with the way the 28-Day Program was being run. He eventually left the program a week or so early and other clients speculated it was because he was fed up. He maintained he just wanted some time to think and to work things out for himself. He had told me a few days prior to his leaving that he thought "the addictions problem was mainly physical" and that staff "had no business trying to pry into psychological or emotional factors."

Other clients told of unhappy marriages causing them psychological stress. One client--who left the 28-Day Program abruptly before its conclusion--said he knew why he had been drinking heavily: his divorce. He maintained that perhaps once he had dealt with the psychological problems associated with that he could again be a social drinker.

Other clients talked about losing loved ones. Martha, for instance, told me about losing her sister in a car accident several years ago and how she had lost her father after he suffered nine years with cancer. She also mentioned that in individual counselling the counsellor, after she had described her sister's death and its effect

upon her, said, "How long are you going to hold on to that one?" That is, how long was she going to continue to use that as an excuse for her drinking.

Other clients mentioned social factors leading to alcoholism. One informant held that, "family problems, job stress and education (or lack of it) causes addiction." Another said that his main problem was a "combination of tension and stress factors in everyday life." Several clients mentioned pressure from friends and relatives to drink. Others talked about the ready availability of alcohol. One man claimed he drank "out of boredom" and one woman claimed she merely drank because she "liked the taste of the stuff."

When asking clients, "What do you think causes alcoholism?", none of the clients stated they believed spirits, Gods or any "other-worldly" factors caused alcoholism, although one young drug addict embraced this idea in conversation. This particular man was very confusing to listen to. One evening I had a long chat with him with the conversation, due to his direction, revolving around religious and mystical phenomena. During the course of the discussion he mentioned he had been reading the bible and that he finally had figured out who he was. In a hushed voice, he stated, "I'm Michael, the fallen angel."

Finally, one client reminded me that, "nobody knows what causes alcoholism, and if we knew that, then we'd know how to cure it."

Treatment and Prevention

Clients told me that if they knew someone who was an alcoholic or had a drinking problem, they would recommend they go to Detox, a family doctor or to A.A. These three avenues of help were the most frequent avenues used by the clients themselves, unless they were "mandatory referrals" from the legal system, a psychiatric hospital or their employers. There seemed to be hesitancy on the part of clients to recommend a family doctor if they had received inadequate treatment from a physician in the past. Clients reported how they had failed to report their heavy drinking to doctors or had merely received tranquilizers from doctors which had only exacerbated their problems. The impression I got was that clients generally felt the Centre to be the best treatment available. This is not to say that some clients were not dissatisfied with aspects of the various programs, some even leaving due to their disenchantment, but most seemed to feel that of all the possible treatments available, this was the best. One client who was removed from the program after about a week, being referred to a psychiatrist, felt that Alcoholics Anonymous was a vastly superior source of help. The man was a staunch

A.A. member and very confused, however, and once even began a monologue in a group therapy session with, "My name is Steve, and I'm an alcoholic," this being the ritual statement with which every speaker at an Alcoholics Anonymous meeting prefaces his remarks. One can only speculate on the reasons why others--especially those who just disappeared--left the Centre. For some, no doubt, it was disillusionment with the treatment they were receiving, and they felt that no treatment was better than that offered by the Centre. Some perhaps felt they needed a drink and left to get one. Also, perhaps those who left the programs would eventually come back to the Centre for outpatient counselling, attend Alcoholics Anonymous or seek out a physician.

Another point which should be raised is the notion of "will power." When asked the question (usually by staff members), "How do you intend to stay sober after you leave here?", clients mentioned Antabuse--the trade name for disulfiram, a drug which produces a mild to severe reaction when alcohol is ingested after taking the drug--outpatient counselling, Alcoholics Anonymous, ex-patient groups, etc., and will power. One man said he had had a 3½ year stretch of sobriety at one point in his drinking career. When asked how he had accomplished this, he replied, "One year of Antabuse, and 2½ years of will power!" Several clients expressed the view that treatment had to be supplemented by

the client him- or herself taking an active role. This was epitomized in the clients' constant reference to will power.

With regard to prevention, clients were sceptical that anything much could be done. Clients mentioned raising the legal drinking age by a couple of years, increasing the amount of education on alcohol and drug problems in schools and offering more information to the general public. But they expressed doubt that any of these measures would be very effective and generally felt that since drinking was such an important part of social behavior, and alcohol was everywhere, nothing much could be done to curb drinking and thus prevent alcoholism.

Discussion

In summary, most clients seem unable to give a cogent definition of the term alcoholism, and often are reluctant to identify themselves as alcoholics. The latter may be due to distorted thinking or denial, but the two processes may also be causally related. That is, lacking an acceptable definition or conceptualization of the condition, clients find it difficult or impossible to tell (or admit) whether or not they have the condition. With regard to classifying alcoholism among various kinds of phenomena, however, clients are better able to say what kind of condition alcoholism is, the disease concept figures prominently into some clients' thinking, while others view

alcoholism as a social problem, a learned behavioral condition, a character defect, or a negative orientation to life. Many clients seemed to hold more than one view of the condition simultaneously. Clients believe alcoholism may be caused by biological factors, psychological factors, the effects of negative life events, or the inability to cope with socio-cultural stress. One drug addict at least hinted that he felt his addiction was the result of an "other-worldly" inspired, pre-ordained fate. Most clients seemed relatively satisfied that they were helping themselves as best they could by attending the Centre. On the other hand there were complaints and some clients left the program possibly because their treatment expectations were not being met. Prevention was generally viewed sceptically.

The overall impression I gained from observing and talking to clients was that they held a variety of rather vague opinions about the meaning of alcoholism. This is reasonable since alcoholism is a complex condition which is still little understood. There is no unified, consistent picture of the problem; scientists, academics, treatment personnel (as we will see below) and the lay public also hold varying views of the nature of alcoholism. It is little wonder, therefore, that clients' conceptions of alcoholism are also diverse and often ambiguous.

The Healers

Who are the Healers?

This section focuses upon healers at the Centre. The term "healer" refers to all those individuals using their powers to promote recovery among clients, but the primary emphasis is upon treatment rather than non-treatment staff.

Of the three months spent at the Centre, all but one week was spent on what is referred to as "the third floor," where the 28-Day Program is given. Staff members of this program therefore were my main informants.

Full-time permanent staff members in this program are five women and one man. All treatment staff are trained to work with drug dependent people through attendance at courses and workshops. Four of the women are counsellors and the fifth is a creative therapist. The man comes in late at night and leaves very early in the morning. He is called "the night man" and is a counsellor-attendant.

The women are responsible for setting up and directing the program, conducting group therapy sessions, arranging passes, handling crisis situations, doling out prescribed medication, and each client is assigned a counsellor for individual counselling. They also supervise the work of students doing practicums. The creative therapist is trained in occupational therapy and her main job is to guide clients through a craft project during their stay at the

Centre. Projects include rug hooking, string art, leatherwork, carpentry, etc. The night man takes charge of any emergency situations, encourages clients to get to bed at a reasonable hour, talks to any clients having problems, asks them to quiet down if others are trying to sleep, and generally tries to maintain a peaceful, orderly atmosphere through the night.

Judy is the head counsellor. She has a nursing background and formerly worked for the Hospital when a treatment unit for alcoholics was under its direction. In 1976 when the Commission on Drug Dependency was established, Judy was one of several staff members who left the Hospital to join the Commission's staff. She is also a recovering alcoholic and a member of Alcoholics Anonymous. Some clients and students find Judy initially intimidating, as I myself did. This is no doubt due to her direct, matter-of-fact, no-nonsense manner. On the other hand, clients and others who get to know her well, speak highly of her, and she obviously puts considerable time and effort into her work.

Two of the other female counsellors have similar backgrounds to Judy; Donna and Lorraine both have nursing backgrounds, and like Judy, both were employed by the Hospital before joining the Commission. Peggy, the other counsellor, has a B.A. degree in the social sciences and a background in social service work. Although these three women are not alcoholics themselves, they have personal

associations with alcoholics. For example, Peggy is married to a recovering alcoholic.

Anne, the creative therapist, has worked with alcoholics and drug addicts for almost twenty years. She views her job as very important and complained to me that counsellors underestimate her contribution to the program. She decries their attempts to devote so much time to group therapy. She admits it is important, but not all-important, as she feels some counsellors view it.

My impression is that Anne and her job are viewed as somewhat peripheral to the main thrust of the program. This is partly due to Anne's independent personality, a smoke allergy which curtails her participation in some program events, the nature of her work, and the fact that the creative therapy workshop and Anne's office are located at the back of the building, while counsellors' offices are at the front.

Besides these permanent full-time staff members, there are a number of other people who, from time to time, or regularly, interact with clients or are otherwise important to the programs. There is the Director, a social worker; the Treatment Co-Ordinator, a social worker, who gives a talk to clients once a month, occasionally sits in on group sessions and oversees student practicums; counsellors and others who may work full-time for the Commission, but are only involved in the 28-Day Program periodically; a physician, a clergyman,

a yoga instructor; social work, nursing and other students; ex-clients; and the cleaning staff. In a sense all the above people may be referred to as healers as they all contribute to the healing process.

One week of fieldwork was spent in the 5-Day Program. A counsellor directs the 5-Day Program on the second floor of the Centre. During my stay at the Centre this position was held by Carol. Like some of the other counsellors, she has a nursing background, and she herself is not an alcoholic. She is aided in her job by members of the Detoxification Unit staff who come in to give talks, direct group discussions, etc., and by students and other staff members who make presentations to the clients.

Healer Conceptions of Alcoholism

How alcoholism is conceptualized varies amongst healers themselves, and in relation to the context in which the subject is discussed. During presentations and group discussions, healers either tacitly express or explicitly explain opinions about alcoholism which they sometimes modifed in private discussion. This is particularly evident in their depiction of alcoholism as a sickness. These differences represent aspects of what Kleinman (1980:109) has called differences between "clinical" and "theoretical" explanatory models. The former he describes as those inferred from "observing practitioners in practice and by systematically

recording what they communicate to patients"; the latter are those elicited from practitioners by researchers.

In the following paragraphs I give examples of conceptions of alcoholism, both clinical and theoretical, of individual Centre staff members. Since I was unable to observe individual counselling sessions or physician's physical examinations, notions about alcoholics used in these private sessions are excluded from the following discussion.

The Director

I spoke with the Director when I first arrived at the Centre some months before fieldwork. He told me about the nature of alcoholism and treatment. He emphasized, "alcoholism is a sickness and has nothing to do with morals, character weakness, or will power." He said anyone can develop alcoholism--from people on Skid Row to executives, and that professionals are particularly at risk.

When I saw him again during fieldwork he gave me a paper he had written a few years ago on the nature of alcoholism. In it he declines to define alcoholism, stating:

> ...I will not be giving you a specific definition of what an 'alcoholic' might be; it might be better if you work out your own definition.

He does, however, portray alcoholism as a sickness--at least for heuristic purposes:

> It may be true that alcoholism is an illness or disease; for those who have difficulty with the disease concept of alcoholism, separate the word into dis-ease and certainly there is a great deal of dis-ease associated with alcoholism in terms of physical complaints, job disruptions, and social embarrassments.

For the purpose of the paper, the Director says that alcoholism may be considered "chronic, progressive and recurring." By chronic, he means the illness is "continuous and persistent over a lengthy period." By progressive, that the illness "gets increasingly worse year after year." And by recurring, that alcoholics "have a tendency toward relapse." He feels there is no cure for alcoholism that would allow a treatment goal of social or normal drinking. He writes, "Until more research is done into this area it would seem that the long range goal of any counsellor should be continued sobriety."

With regard to time and mode of onset of symptoms, the Director writes that there is usually a developmental period of from five to twenty years. He also mentions there is thought to be a sex difference in that women often develop alcoholism in a comparatively short length of time, and that the onset of the condition more frequently seems to be triggered by traumatic life events. He claims it is often persons other than the alcoholic who first seek out treatment. Symptoms mentioned include those related to family, social, employment and economic problems. Little mention is made

of physiological complaints, although in a series of questions in another section of the paper, the Director refers to memory "blackouts," morning "shakes," emotional problems, depression, hallucinations, tolerance, etc. He envisions these and other symptoms as appearing in three stages which he labels: Early Stage Alcoholics, Middle Stage Alcoholism, and Last Stage Alcoholism. He notes,

> Alcoholism is a form of denial, the alcoholic is locked in a phase of resistance to treatment. If the family accepts this denial and refuses to break the lock, many alcoholics will die, because alcohol for them seems on the one hand to be a psychological blessing but on the other hand a physiological curse.

Regarding etiology, the Director points out, "Its causes are unknown." He also writes, however,

> Inability to recognize their illness is almost universal among alcoholics.... Despite ample evidence to the contrary, such a person believes the misuse of alcohol is a result, rather than a cause of their troubles.

In the Director's view, stress contributes to illness episodes. He writes:

> Many alcoholics manage to establish and maintain periods of sobriety for some time but return to drinking because they are not prepared for some of the difficulties usually experienced during recovery from long term alcoholism.... The first two real problems confronting many alcoholics as they start out life in complete sobriety are employment and financial difficulties....

To summarize, the Director portrays alcoholism as an illness or sickness, but declines to provide a specific definition of the condition. He regards etiology as unknown, although sickness episodes may be triggered by anxiety and stress. There is a long development period with those close to the afflicted person often first acknowledging that treatment must be sought. There are various behavioral and physiological symptoms, and the sickness is chronic, progressive and recurring--and sometimes fatal. It is incurable, although treatable, and the treatment goal should be abstinence. Another general point the Director makes is that alcoholics almost universally see drinking as a result--not a cause--of their problems. This differs from a view in which alcoholism is portrayed as causing various social, economic and emotional problems, but agrees with the view that traumatic life events and employment and financial difficulties may lead a person to use alcohol as a coping strategy.

It should be noted that the paper from which much of the above was extracted was presented to employers to help them develop employee policies on alcoholism. Further, the Director is not directly involved in treatment at the Centre. The views presented, therefore, represent a theoretical and not a clinical conception.

But the Director's views do relate to treatment. For example, alcoholism is conceptualized as a sickness and abstinence is the treatment goal, and staff members, although

apparently free to formulate and express their own views on alcoholism, are neither ignorant of nor impervious to statements by their Director, such as, "it would seem that the long range goal of any counsellor should be continued sobriety."

The Treatment Co-ordinator

The Treatment Co-ordinator oversees treatment programs and student practicums, and gives one lecture a month to clients--among other duties. From his lecture, which can be considered a clinical explanation because it is directed towards clients, the following view of alcoholism emerges.

The Co-ordinator defines alcoholism as,

> ...a condition in which the repeated use of alcohol has an eventual adverse effect on the drinker's general health, emotional stability, job, social, financial and family situation.

He says he means to contradict medical people by calling alcoholism a condition rather than a disease. He claims the only thing alcoholics have in common is habitual use of alcohol:

> There is nothing special about alcoholics. The only thing alcoholics have in common is repeated use.

This implies no unitary, prior psychological, physiological, social or other characteristics cause alcoholism. He feels

the condition affects people physically, emotionally and spiritually. And alcoholism is not fatal *per se*, but does affect mortality rates.

An implication of his viewpoint is that alcoholism is a learned, and therefore, extinguishable condition. Although he does not say so in his lecture, the possibility of a return to social drinking is not eliminated.

In short, the Treatment Co-ordinator defines alcoholism in broad terms which include drinking problems associated with social, physical, and spiritual problems; classifies it as a condition, rather than a medical disease or illness; views the cause as repeated use of alcohol; and implies that problems are the result, not the cause of the condition. A further implication is that the condition is learned and therefore extinguishable.

A Part-Time Counsellor

The counsellor whose conceptions are described below is a full-time Commission employee, but is not a full-time counsellor at the Centre. From this man, I elicited the following theoretical explanation of alcoholism which runs contrary to the main thrust of the treatment programs. This counsellor is critical of what goes on at the Centre, particularly staff authoritarianism and the focussing of responsibility on the individual client. He also views the Centre's activities as of a

"band-aid" nature and suggests treatment is a form of social control, maintaining that if nothing was done about alcohol and drug problems sooner or later people would rebel, and to keep them from rebelling the Centre continues to exist. At one point in a conversation he drew a parallel between giving aid to Third World Countries as a band-aid solution to problems of inequality of access to resources. Without institutions such as the Centre, he suggested that people in our society would rebel and demand their rights.

He seems to prefer a more individual approach to alcohol problems, and says that only after a client and himself have established a trusting relationship does he feel "confrontation" is in order.

He suggests "excessive drinking" is a learned response to anxiety levels that differ amongst indviduals. Anxiety-arousing conditions mentioned include marital situation and job stress. He suggests that psychological problems are often present prior to the development of alcohol-related problems.

His theoretical explanation, therefore, includes "excessive drinking" (he avoided the term "alcoholism") as a learned response to anxiety levels; and he notes the disease concept has been encouraged for political reasons and to change the public's image of the alcoholic. Etiological explanations include the notion that some

alcoholics can have pre-existing psychological problems, but that excessive drinking itself causes such emotional problems as anxiety and distortion of reality. Since he views the condition as involving learned behavior, it is viewed as potentially extinguishable.

I do not have full information on his clinical explanation as I only observed his participation in a few group sessions. The following incident, however, illuminates his clinical view. In one group therapy session, a male client, approximately 30 years old, said he felt that his individuality was being threatened and that he was feeling a lot of pressure from the group to accept sobriety as his long-term goal. He maintained that he knew why he had been drinking excessively--his recent divorce--and that perhaps once he had solved problems and emotional turmoil associated with this, he would then be able to return to social drinking. Other group members pounced upon him, suggesting he was merely "kidding himself" and minimizing his problem. The counsellor in question, however, said, "Well, you're not getting any pressure from me. I happen to agree with social drinking. What you have to do is distinguish between 'escape drinking' and 'non-escape drinking'." He noted further that re-learning to drink socially or in a 'non-escape manner is not always successful, however, as it involves learning to cope with anxieties without the use of alcohol, and this is generally a long, hard process. This was the only time in

my three months of fieldwork that I observed a healer giving explicit recognition to 'return to social drinking' as a possible treatment goal.

Full-Time Counsellors

The clinical conception of alcoholics promulgated by full-time counsellors, either explicitly or tacitly, is one of alcoholism as a serious problem affecting emotional, behavioral, cognitive, social and physical functioning. The problem is generally presented as a sickness which is primary, progressive, incurable and sometimes fatal. The general impression counsellors give clients is that etiology is largely unknown. One day in group a client brought up the matter of the genetic basis of alcoholism. The discussion was terminated, rather quickly, however, with one of the counsellors declaring that "the evidence is controversial," and adding that the results of drinking are of more importance. In other words, she suggested that etiology is not known and, in any case, is rather unimportant; the important matter is the damage caused by drinking.

Abstinence is the treatment goal, and counsellors urge clients to avoid drinking situations. For example, one client who claimed he had no intention of stopping his attendance at bars was told he was being naive. A counsellor said, "Sooner or later temptation will overcome you."

In discussing alcoholism with counsellors privately, two views on alcoholism emerged. One view is that alcoholism is a disease or illness. The other is that it is probably not a sickness, but for clinical purposes it should be so promoted. These are theoretical explanations. One counsellor said she had begun to have doubts recently. She said, "I have some trouble with the concept and sometimes feel it's better to refer to it as a condition--although this can give the erroneous impression of allowing for a return to social drinking." Another told me, "The disease idea is really starting to worry me; I'm sick of the pretense. We've all been brainwashed." She told me that when clients ask about it she is non-commital and tries to present different theories of the condition and let them make up their own minds. In observing her in practice, however, she called alcoholism a disease and illness without qualification and I observed no presentation of alternative views.

The impression I gained is that counsellors explicitly or tacitly promote sickness concepts amongst clients. They seem to (consciously or unconsciously) try to present a unified picture of alcoholism which accords with a disease concept, does not stress any particular etiology, views problems as the result of drinking (not the cause) and promotes abstinence as the proper treatment goal.

It should also be noted, however, that classifying the condition did not seem to be an important issue to some counsellors. Counsellors told me that emphasis had shifted from a focus on drinking per se to a focus on coping with life problems. One counsellor said, "I don't think it really matters what it's called" and later referred to alcoholism as "a disease, illness or whatever." Judy, however, herself an alcoholic, reprimanded a client in group for making a "judgmental" distinction between Skid Row alcoholics and "binge drinkers" and implying that binge-drinkers were not as "bad" as the former. Judy reminded the group: '"We're all sick."

The Students

Student conceptions presented in the following paragraphs influence treatment in that students are actively involved in treating clients. Social work students, from which the following information was gathered, are assigned clients to counsel, and they present talks to clients on occasion, besides interacting with clients informally and in group sessions.

The following discussion illuminates aspects of theoretical conceptions held by Barb, a social work student. We were sitting in our shared offices when a Commission staff member, who is not directly involved in treating clients, 'dropped in.' The staff member asked me about my research

and I told him one of the things I was investigating was the disease concept of alcoholism. I then asked him if he thought alcoholism was a disease. He replied, "No. I've never bought that crap! Why do you?" After some discussion, he described "'alcoholism,' in quotes" as a learned behavioral response which society has deemed inappropriate and labelled an illness. He said he felt anything could become a disease if society so chose. Barb said she agreed with this, and added that because alcoholism is "self-inflicted" it cannot be a disease in the usual sense. She also pointed out that the Treatment Co-ordinator felt it was a "condition" and that she agreed with this classification. She felt that calling it an illness or disease shifted responsibility away from the individual and allowed the individual to "sit back and wait for treatment."

Shirley, another social work student, gave a talk on alcoholism to clients which revealed aspects of her clinical view. She characterized alcoholism as a "family illness." In her view the whole family is sick, and this sickness is one which develops over time, passing through several stages until the whole family system breaks down or treatment intervenes. Her talk was interspersed with insights gained from her own experience with an alcoholic husband. She claimed to have thought herself mentally ill until she joined Al-Anon and learned how to cope with

the problem which nonetheless resulted in a permanently broken marriage. Like the Director, she felt it is the family's responsibility to help the alcoholic recognize and seek treatment for his or her problem, and that other family members may also require treatment.

These two student conceptions are very different. Barb sees alcoholism as a learned behavioral, self-inflicted condition largely defined by society, whereas Shirley views the condition as a family illness, progressive in nature causing severe family problems, and dependent upon faulty family interaction for its development and continuance.

The Clergyman

The clergyman, Bob, is in his late forties or early fifties and has been sober for about 20 years. He still considers himself to be an alcoholic, however, and feels his salvation from alcohol was due to a spiritual awakening. Bob looks upon alcoholism as a problem associated with the emotional, physical and spiritual domains of life. This is the clinical viewpoint expressed in group discussion.

He talks about guilt and the necessity for surrender to a higher power. He also speaks about the inability of alcoholics to cope with loss and he refers to their "con-artist" nature--explaining that alcoholics "con" themselves as well as others.

In discussion with clients he tends to portray alcoholism as a disease or illness. He talks about Christ's healing miracles, one in particular in which Christ first asks the victim if he wants to be cured. Then Bob asks the group members if they too want to be cured, adding, "Is the disease worse than the cure?"

He suggests that, "once an alcoholic, always an alcoholic" and that abstinence is the indicated treatment goal. But in order for the alcoholic to be sober and happy, Bob maintains that he or she must aim for "contented sobriety" which he feels necessitates a spiritual or existential change.

This, then, is his clinical explanation: alcoholism is a kind of sickness with emotional, physical and spiritual components and of life-long duration. Moral implications of his conception are revealed in the emphasis upon guilt and forgiveness from a higher power. Although a person may be abstinent, contented sobriety is achieved through spiritual surrender. This is a non-denominational surrender in that it incorporates the idea of a "higher power" (or God whatever one conceives it to be)--a concept also promoted by Alcoholics Anonymous.

Bob's theoretical explanation differs somewhat from his clinical explanation. For instance, when talking with him privately on his conceptualization of alcoholism during my final week at the Centre, he told me he questioned the

idea of alcoholism as a sickness. He said he was well aware of the controversy over the portrayal of alcoholism and suggested that this was why it was becoming increasingly unpopular to conceptualize it in sickness terms. I was surprised by this revelation because everything he had said in discussions with clients indicated he adhered to a sickness concept. Perhaps he felt the sickness concept helped clients contend with the guilt accompanying alcoholism which he frequently spoke about.

The Physician

The physician conceptualizes alcoholism in his talks to clients as an illness affecting many aspects of life. In his lecture on the physical effects of alcohol, he describes a long list of medical conditions resulting from excessive alcohol consumption. He also notes that today there is less of a tendency to separate mind and body, and suggests behavioral responses are often a result of physiological disturbance. As an example, he even suggests that aspects of an alcoholic's "irresponsibility" may be linked to brain damage from alcohol consumption.

It is clear from his manner and his talks, which seem designed to educate and instill fear in clients, that he views alcoholism as a serious health problem and one in which the alcoholic him- or herself should assume major responsibility for recovery.

Discussion

Only an occasional definition is offered of the terms "alcoholism" and "alcoholic" by healers or in films, video tapes, or Centre literature. The following definition--although of drug dependency (which includes alcohol dependency or alcoholism)--is typical of the kind of definition given:

> The Staff...share a common belief, in that drug dependency is a condition which is developed by excessive consumption or intake of a preferred drug to such an extent that drug consumption interferes with, and effects bodily and mental health, causes financial, social, and family and employment problems, but does make easy an already established life style. (28-Day Resident's Handbook, Appendix III. p. 178)

Such a definition is very general, and permits a broad spectrum of clients to adopt the "drug dependent" or "alcoholic" label. In this definition drinking per se is de-emphasized in that no specifics are given about drinking characteristics except to note that consumption or intake is excessive and results in problems.

Alcoholism is classified by healers as a sickness or condition associated with a variety of problems. These problems--as indicated in the above definition--are viewed as the result (not the cause) of excessive drinking. There are also, however, indications that some healers recognize the existence of pre-existing, pre-disposing factors. These

pre-existing factors may include biological susceptibility, psychological susceptibility, character weakness or spiritual shortcomings. This is apparent, for example, in the part-time counsellor's suggestion that clients often tend to have psychological problems prior to becoming excessive drinkers and Alcoholics Anonymous' notion of alcoholics being allergic to alcohol. But, in the main, alcoholism is looked upon as the result of excessive drinking, and anyone has the potential for becoming an alcoholic.

There is some discrepancy between clinical conceptions and theoretical conceptions of alcoholism. The main thrust of the programs is toward depicting alcoholism as a sickness. Some healers are in disagreement with this viewpoint and do make their particular views known to clients. Other healers, however, give tacit or explicit approval to the concept while expressing doubt or disagreement with the concept in non-clinical contexts.

Comparison and Contrast of Client and Healer Conceptions

Both clients and healers are vague in their definitions of alcoholism, or define it so broadly that the label "alcoholic" is broadly applicable. When classified among behavioral conditions alcoholism tends to fall into a sickness category, although some members of both groups disagree with a sickness concept. The main point of difference between the two groups is with regard to etiology.

Although both groups tend to view alcoholism as of unknown or uncertain etiology, clients frequently mention unhappy childhoods, family problems, peer pressure, job stress, lack of education, lack of achievement, and other problems that predate their alcoholism or account for their developing drinking problems. Healers, on the other hand, nearly always see a client's problems as stemming from their excessive drinking. Part of the healing program is to get clients to relinquish these "excuses," encourage them to "face the reality" that drinking causes problems, and to cope with current problems without resorting to alcohol use. The problem of etiology is somewhat sidestepped in favor of focusing upon ways of coping with present life situations. If problems are the result of drinking, treatment is directed toward amelioration of the results of the development of alcoholism, not why people begin drinking heavily in the first place. Thus, although treatment may help a client deal more effectively with present and future living problems, it fails to seek out and treat the root causes of the problems. Perhaps individual counselling helps ferret out these specific causes, but the overall impression gained from observing treatment is that causes are left buried in the notion that anyone can become an alcoholic and drinking *per se* is responsible for alcoholism.

CHAPTER V

CONCLUSIONS

Introduction

This chapter summarizes salient points from previous chapters and draws conclusions relevant to theoretical and practical issues.

The theoretical issues addressed relate to our growing understanding of medical systems, but an equally important function of the results is related to practical treatment of drinking problems.

Theoretical Implications

The main theoretical importance of the results lies in their relationship to our understanding of medical systems. This Thesis attempts to increase our knowledge of what happens when a condition formerly defined as a spiritual, legal, moral or criminal problem--i.e., a non-medical problem--moves into the medical realm. People in our society still hold varying conceptions of alcoholism. At the Centre alcoholism is mainly--though not invariably--treated as a disease or illness, yet staff members are non-medical practioners. The data gathered in this study suggest that when a condition is not well understood and there is no consensus that it is a medical condition, the healing process will display inconsistencies that may be counter-therapeutic.

My findings indicate that participants in the healing process at the Centre hold varying conceptions of alcoholism. The condition is either broadly defined, generally based on the consequences of drinking, or its definition is left unstated. It is also variously classified both by clients and healers. Etiological views differ among participants. Treatment components and methods are multiple and there is some disagreement as to whether abstinence is the only legitimate treatment goal. On the basis of such diversity, it is suggested that treatment at the Centre is not guided by what Press (1980:47) termed,

> A patterned, interrelated body of values and deliberate practices, governed by a single paradigm of the meaning, identification, prevention, and treatment of sickness.

This lack of consistency is related to our society's vague and ambivalent stance toward alcoholism, as well as to our difficulty in distinguishing between sickness and health. Formerly, alcoholism was regarded as a moral failing, spiritual, legal and/or criminal problem. Alcoholics Anonymous, influential writers such as E.M. Jellinek and others then promoted a sickness concept of the problem which raised the alcoholic's self-esteem and public image, and was influencial in obtaining more humane treatment. More recently there has been criticism of the medicalization of such problems as delinquency, homosexuality, promiscuity,

drug abuse and alcoholism. This is resulting in a growing rejection of a sickness concept of alcoholism--as a backlash against this trend--and a tendency toward viewing alcoholism as a learned "condition." Treatment at the Centre reflects all three of these viewpoints: there is still some conception of alcoholism as a moral failing or spiritual problem, and some clients are at the Centre ostensibly for legal or criminal reasons; the disease or illness concept is predominant; and, in keeping with the new trend, some participants conceptualize alcoholism as a learned behavioral disorder.

The Thesis presents data showing that healers at the Centre tend to focus upon physiological, and particularly psychological factors associated with alcoholism, and tend to downplay sociocultural factors relevant to the condition. This is a culturally-particular view of the condition, and as Blacker (1973:99) comments:

> In the United States and Canada students of alcoholism view alcoholism as an illness or a symptom of an illness accompanied by psychological disturbance, but international studies suggest that other definitions are possible....if comparisons between nations show that the sociocultural context in which drinking arises can influence the very definition of alcoholism, this should alert us to the possibility that American definitions of alcoholism can be influenced by sociocultural factors.

Furthermore, as Armor, Polich & Stambul (1978:24) note, theories of alcoholism which invoke "internal determinants,

such as physiological malfunctions, psychological traits, conditional associations, or habituated responses" are doubtful when the strong empirical relationship between sociocultural factors and alcoholism is considered.

Findings tend to support the contention of many writers that our Western medical system ignores or leaves unstressed factors of utmost importance to other medical systems. Rather than deeply explore interpersonal problems such as competition, greed, jealousy and lust--which may lead a person to become an excessive drinker, treatment focuses upon the person as the locus in disrupted physiological and psychological processes. The healing process considers disruptions in the individual's interpersonal realm, including life changes, as the result--not the cause--of alcoholism. To some extent this may be true, but it is also true that the greater number of life changes a person experiences the more likely he or she is to become ill. The healing process further largely ignores the epidemiology of the condition by failing to present a picture of the risk factors making some groups of individuals more likely to develop the condition than others. These risk factors include biological characteristics such as age, sex and ethnicity--or more or less unchangeable host characteristics. They also include factors such as social class, occupation, geographic location, and other situational factors.

Given ambiguous conceptions of alcoholism, the lack of complete understanding of the condition, and the lack of emphasis on sociocultural factors, the healing process may fail to give clients meaningful explanations of their drinking problems and how they come to develop alcoholism.

With regard to the problem of stigma, clients are exposed to a healing process which attempts to redefine and culturally transform alcoholism into a sanctioned sickness or condition. "Drunks" or "drinkers" become "sick alcoholics" or "drug dependent." This is mainly accomplished through the manipulation of labels or concepts by presenting medical and other "facts," and to some extent by showing how myths about alcoholism and alcoholics are false. The process may also be viewed as analogous to a rite of passage whereby the client is separated from his everyday realm and social structure, passes through a realm wherein his status is ambiguous; and ideally emerges in a more socially stable state. Data suggest, however, that the process fails to fully redefine and transform alcoholism into a non-culpable condition, and some aspects of the process even seem to perpetuate or accentuate guilt. Given this incomplete or faulty transformation process, clients seem unable to consummate a true passage into a more stable state. That is, they leave the Centre as stigmatized alcoholics and although they may take up or resume "normal" functioning they are nevertheless deprived of normal status.

One of the issues in Canadian health-care policy has been referred to as the "individual-versus-structure" debate (Coburn et al., 1981:442). One viewpoint states that our society is becoming too medicalized and that individuals should assume greater responsibility for their own health. The other viewpoint argues that the structure of our society is at fault, and that the solution to medical problems lies in changing society's basic structure. As has been noted, healers at the Centre generally identify the individual as the locus of the problem. They characterize their role as one of guiding or helping the individual to change his or her lifestyle. They encourage clients to take responsibility for their own health and be the "prime movers" in recovery. As a result of this orientation sociocultural factors resulting from the structure of our society are underplayed.

It would seem as though treatment at the Centre could be improved by taking both these viewpoints, i.e., "individual-versus-structure" into account. Individuals could assume much of the responsibility for their own health care, and resist the continuing expansion and power of medical professions. To do this, however, it is necessary to become aware of facts and myths surrounding alcoholism--including those related to sociocultural factors contributing to the condition. In order to deal with their problem drinking, clients should be given systematic and comprehensive knowledge about the condition including information on

psychological, physiological, spiritual, social, cultural and all other pertinent factors. They should, in effect, be educated as to how the social structure may influence or even cause alcoholism.

The main theoretical implication of the findings is that when there is disagreement about what conditions should be included for treatment in the medical system, how much responsibility and blame individuals should assume for a particular condition, and the extent to which social structure causes the condition, the healing process is truncated or not as potent as it could be.

Practical Implications

Results of the study are relevant to treatment issues. Firstly, if healers are interested in encouraging a reduction in alcoholism through giving individuals a sense of responsibility for their own actions and recovery, then clients should be given honest, comprehensive knowledge about their conditions to enable them to identify sources of trouble and institute remedial action. There should, for instance, be discussion by healers of the various ways in which alcoholism is defined. What are the specific criteria upon which the diagnosis of alcoholism rests? Is it sufficient to diagnose alcoholism on the basis of assumed consequences of drinking, such as economic, employment or marital difficulties? Or, if some aspect of the drinking

per se, such as "loss of control" is the diagnostic hallmark, then exactly what does this term mean? Some writers have suggested that the term "alcoholism" is non-definable. Schmidt (1973:15) writes:

> ...none of the definitions available today describes objectively the drinking behavior of all alcoholics...Each of these definitions describes the drinking of an unknown proportion of an alcoholic population, and it may well be that a single definition covering all alcoholic patterns is impossible. It is probably more useful to think of alcoholisms rather than of a single entity, and to define these various manifestations separately.

Problems with the term "alcoholism" should be fully discussed with clients, its shortcomings identified, and substitute terms--such as drug dependancy, which appears in the Centre's title--fully discussed as well. Rather than being unimportant, what a condition is called is the initial step in the healing process and the application of any diagnostic label to an individual or his or her condition has important consequences. Roman and Trice (1977:53) point out:

> The individual with the medical diagnosis of alcoholic or deviant drinker occupies a social status which has accompanying role expectations, the principal expectation being engagement in deviant drinking practices. This is illustrated by the fact that we are not surprised to see a drunk alcoholic and we marvel with amazement when we see a sober one.

Similarly, it would perhaps enhance the healing process if the classification of alcoholism was more openly discussed.

If healers have doubts about whether or not alcoholism is a sickness, these should be presented to clients--even if this brings into question abstinence as the only legitimate treatment goal. Clients should be presented with current theories and trends in the field, not just those that accord with traditional views or are deemed clinically efficient.

With regard to etiology, clients should also be given a full picture of the multi-causal agents precipitating the development of alcoholism. It is insufficient to state that the "causes of alcoholism are unknown" or to focus upon the presumed results of alcoholism. Enough is known of the etiology of the condition to present clients with information enabling them to relate factors such as their sex, age, social class, occupation, geographic location, ethnic identity, as well as particular life events and stresses to the development of the condition. Instead of downgrading the positive functions of alcohol use, it may also enhance the healing process to foster an appreciation of the positive functions of alcohol use in particular contexts. Such an examination would help clients more fully understand our society's ambivalent stance toward alcohol use and abuse, and present a more realistic picture of what abstinence and social drinking entail.

Some readers of this Thesis may question the wisdom and feasibility of providing clients who are seeking help with "quandaries" rather than simple, straight-forward answers.

Two responses can be made to this query. Treatment as it now stands provides clients with quandaries due to its contradictions and inconsistencies. For example, one client at the Centre argued:

> They tell us you're sick and have no control over alcohol...and will power is useless. But you have to promise to stay sober for 28 days, and if you don't they'll boot you out!

Giving clients a fuller, more realistic view of alcoholism may, therefore, simplify rather than complicate clients' conceptions of their conditions. Second, if clients are given more information they will be better able to direct their recoveries and be in better positions to institute needed changes--in themselves and/or in society. That is, they will be in more favourable positions of power from which to resist the growing hegemony of medical and related professions, and to help change sociocultural conditions contributing to alcoholism.

Although these changes may be difficult to institute, the healing process would probably be enhanced if family, friends, employers and other significant persons could be more involved in treatment and in the client's re-emergence into society. It would also help if members of the community and society at large could recognize the ambiguous stance taken towards drinking and the nature of our drinking patterns. Prevention and treatment should ideally go hand

in hand. In short, we should examine the question of why our society is drug oriented, and not just why some people become alcoholics. As much as possible clients should be made to realize that, if alcoholism is a sickness, it is society as a whole that is "sick," not just individuals. This is a needed adjunct to the notion that clients themselves are responsible for their conditions.

Practical Relevance to Newfoundland

One of the intended purposes of this Thesis is to provide ethnographic material on the healing process in a modern, functioning treatment centre. To the author's knowledge, data presented in this Thesis are unique in that there has been no other ethnographic study of a treatment facility in Atlantic Canada.

It is to be hoped that some of the information presented here will be pertinent to the planning and establishment of full-scale facilities in Newfoundland which are presently non-existent. The Alcohol and Drug Addiction Foundation of Newfoundland and Labrador's Executive Director claims Newfoundland is some 15 years behind the province in which the study was conducted in providing treatment facilities for problem drinkers. At present most alcohol problems in St. John's are treated in psychiatric wards, a small facility attached to St. Clare's Hospital, by religious groups, Alcoholics Anonymous and other self-help groups, and family doctors. Alcoholics also seek

aid in other provinces. By contrast, the province in which the data for this study were gathered operates a network of varied treatment facilities, ranging from detoxification units to long-term sheltered group houses. This province has been divided into five regions, each with its own semi-autonomous regional board, and a provincial Commission oversees and coordinates regional activities.

It is expected that Newfoundland will soon provide additional services for its problem drinkers, as a provincial Commission has just been established for alcohol problems. Components of the functioning, modern treatment centre described in this study may prove valuable in planning Newfoundland's new treatment facilities. Likewise, aspects of the treatment process described may be improved upon or excluded from future facilities and healing efforts.

As suggested in the previous paragraphs, clients being treated for problem drinking, if they are to assume a large proportion of responsibility for their conditions and recovery, should also be given full information about the nature of alcoholism or drug dependency. This includes not only information on physiological and psychological processes associated with the condition, but also must include information on sociocultural factors precipitating the condition in the Newfoundland context. In order to present clients with such information it will be necessary to undertake more research on drinking patterns in

Newfoundland and the epidemiology of alcoholism in the Newfoundland context.

Definitions and classifications of the condition should also reflect conceptions held by Newfoundlanders themselves, as much as this is possible, so that clients are able to find personal meaning in the healing process.

In short clients should come to have an understanding of the degree to which they themselves are responsible for their own conditions as well as an understanding of alcoholism. Ideally, Newfoundlanders in general should similarly strive for such understanding so that a unified picture of the problem can be brought to bear on the prevention and treatment of alcoholism.

APPENDIX I

LETTER OF CONSENT

APPENDIX

TO WHOM IT MAY CONCERN:

As part of a project on alcoholism, a study is being conducted to determine the manner in which clients coming to a treatment centre conceptualize alcohol problems. Questions will be asked concerning how clients define and classify alcohol problems, and how they conceive of what causes alcoholism.

Your co-operation in the study would be very much appreciated. You may be assured that all information gathered will remain strictly confidential. Participation in the study, of course, is voluntary.

If you agree to participate, please indicate your consent by signing below.

Sincerely,

Margaret L. Jones
Graduate Student
Memorial University of Newfoundland

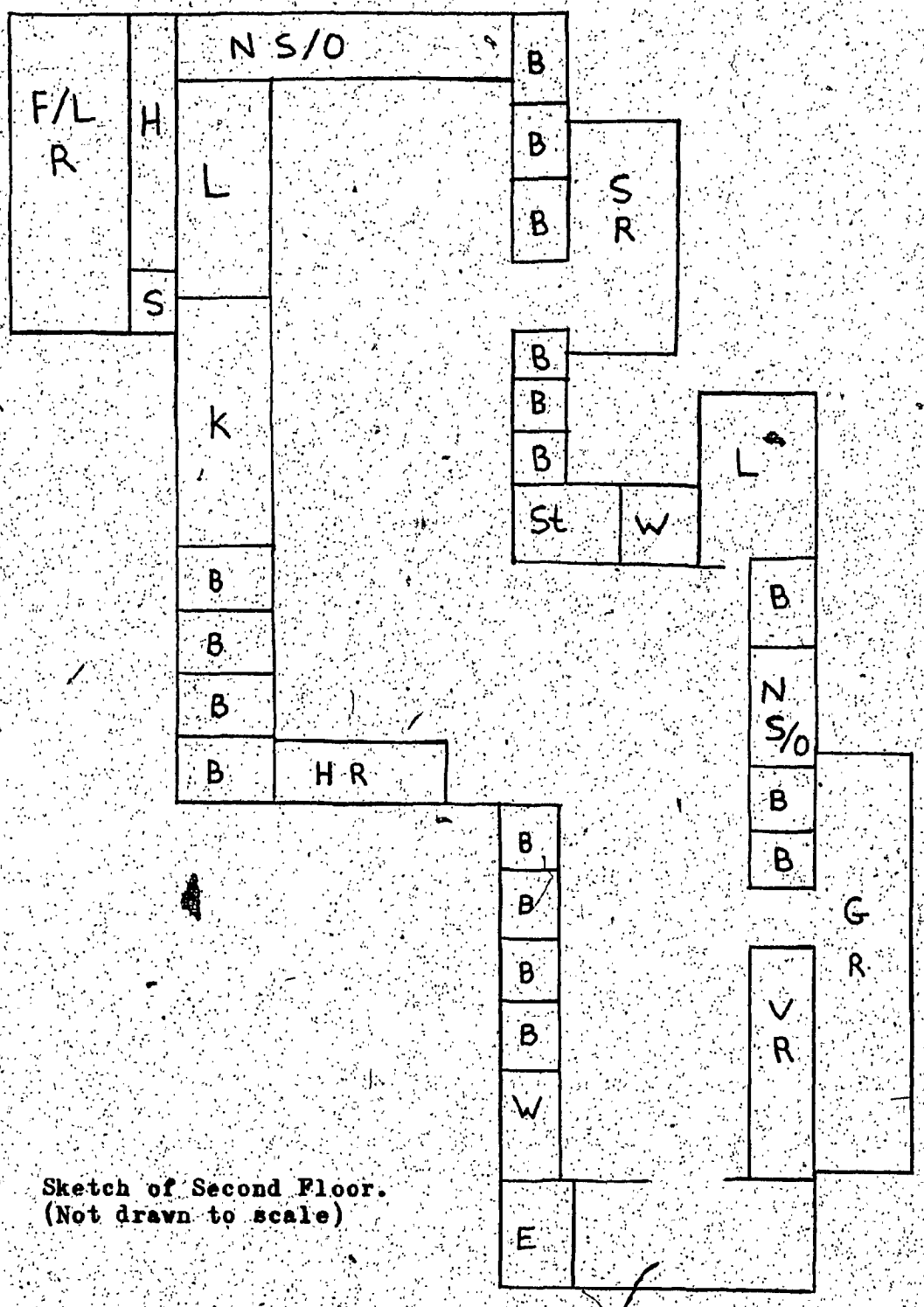
Consent of Client _____

APPENDIX II

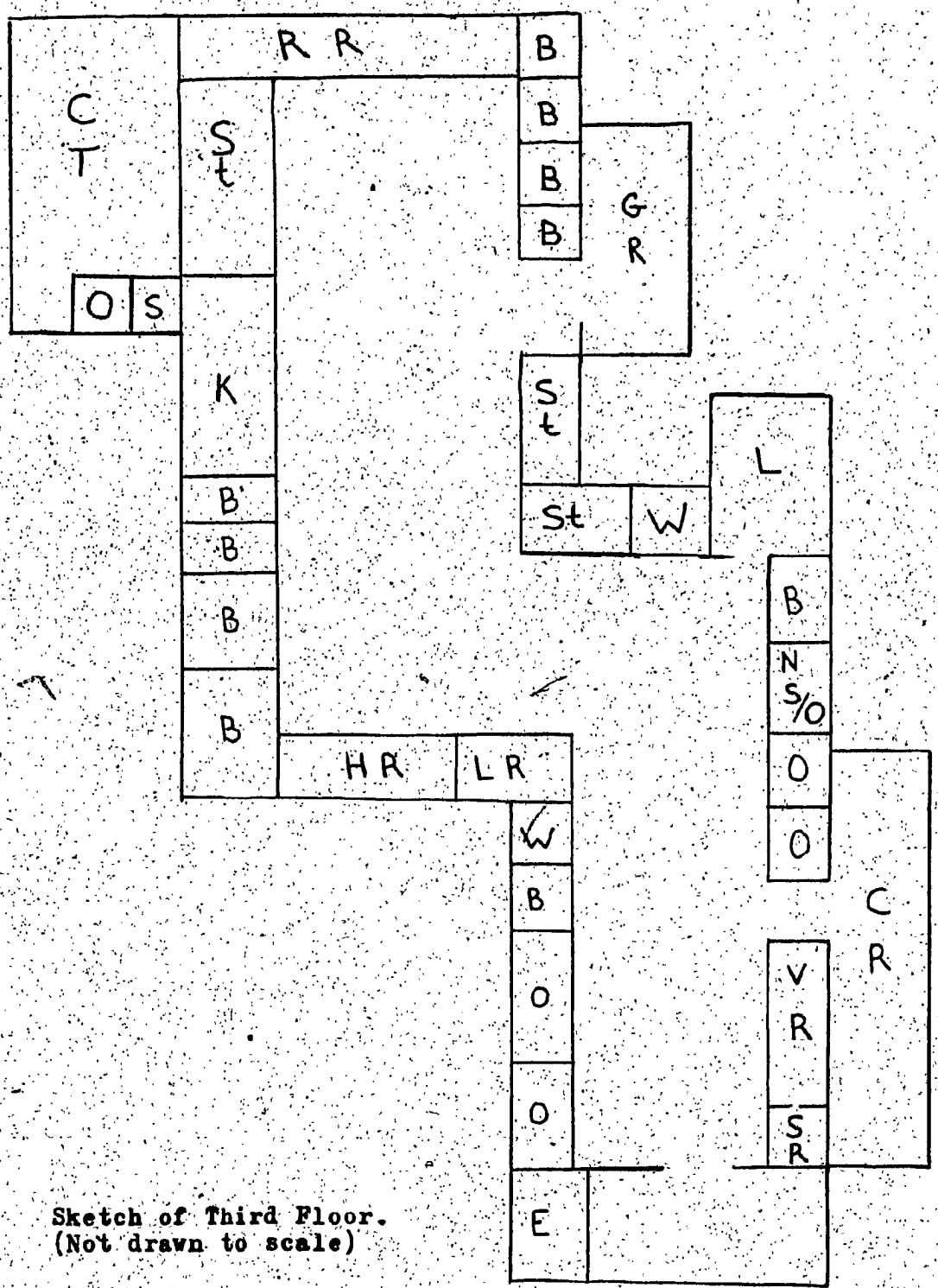
CENTRE FLOOR PLANS

KEY TO SECOND AND THIRD FLOOR SKETCHES

B	-	Bedroom
CT	-	Creative Therapy
CR	-	Common Room
E	-	Elevator
F/LR	-	Film/Lecture Room
GR	-	Games Room
H	-	Hall
HR	-	Housekeeping Room
K	-	Kitchen
L	-	Lounge
LR	-	Laundry Room
O	-	Office
NS/O	-	Nursing Station/Office
RR	-	Reading Room
S	-	Stairs
St	-	Storage
SR	-	Staff Room
VR	-	Visitors' Room
W	-	Washroom



Sketch of Second Floor.
(Not drawn to scale)



Sketch of Third Floor.
(Not drawn to scale)

APPENDIX III

5-DAY PROGRAM MATERIAL*

28-DAY PROGRAM MATERIAL*

* The texts have been reproduced as given in the original documents.

PRIMARY CARE:

THE TREATMENT ORIENTATION PROGRAM

October, 1980
(Revision)

The Expanded Program - Goals and Objectives:

The purpose of this expanded program will be to present to the Primary Care patients concepts, information, and support, that, if acted upon will assist the patient in the recognition of their condition. The program will also reinforce the idea that the patient must be the prime mover in their own recovery and that facilities, programs, staff and medications exist, only to facilitate the recovery process.

The type of counselling that will be utilized must be able to achieve the above stated goals within a short space of time. It will emphasize short term crisis counselling methods aimed at helping the patient to cope constructively with their current situation, and assist in the overall assessment process.

It will employ both confronting and supportive methods in helping the patient to face reality and function more responsibly. The goal will be to facilitate self-appraisal in their present milieu with the aim of encouraging constructive behavioral change via ongoing educational support and participation in the various treatment programs available.

Guidelines for Selection:

The Orientation component will not, of course,

negate the core Detoxication program. However it will call for the staff of Primary Care to better classify patients so that the economy of treatment can be enhanced. Following is a suggested topology:

1. Detox only
   - those patients who, due to situational factors elect to stay only the minimum amount of time
   - those patients who have recently had the orientation program but apparently reject its concepts appear to fail to show any productive sober behavior

Orientation Program - Eligibility

All patients accepted on the Program will be sober for at least 3 days on no mood altering medications and have no significant health problems. Following are those persons eligible to participate in the Treatment Orientation Program:

(A) those patients who have been admitted to Primary Care for the first time:

(1) those who are willing to participate and request the program;

(2) those who will deny having a drug

dependency but have been encouraged to take the program for its educational benefits;

(3) those who will be a mandatory referral from either the employer or the legal system;

(B) those patients who have been through Detox and show only marginal or limited gains in recovery but show a genuine interest in starting anew;

(C) those patients who have taken the Orientation Program before but show a new initiative to participate again. Such a change in motive will be certified by a staff person and will be at least one year in duration since taking the program last;

(D) those patients who will be recommended by staff:

(1) not that well motivated to participate but perceived as needing a longer Detox period to ensure any chance of sobriety.

(2) have taken previous treatment programs (such as Short Term Treatment Program) but desire a refresher course in drug dependency to help remotivate them toward sobriety or abstinence.

(E) those persons who are not patients of Detox but are:

(1) staff personnel from other agencies, institutions or even other departments of Commission on Drug Dependency who are seeking an intensive, short-term orientation to drug dependency education and treatment.

(2) Community or Outpatient Department referrals that have been sanctioned by the Treatment Orientation Program Leader.

Contents of the Program:

The Program will run from Monday through Friday inclusively. Activities in the program will be broken down into the following areas:

(A) Education: 1) A presentation will be given aimed at helping the patient to identify the nature of their dependency in relation to the resources available in treatment and support system in a continuing health care concept;

2) A presentation will be made

on all aspects of deterrent therapy;

3) A presentation will be made on the development and effects of drug dependency;

4) A presentation will be made on recovery, plans and follow-up;

5) A presentation will be made on nutrition and alcohol related illnesses;

6) Recovery Process.

These presentations will be no longer than 45 minutes in duration and will be followed up by a question and answer period.

(B) Work Therapy: Since all patients in this expanded Program will be detoxified then they will be expected to help in the upkeep of the detox unit. To this end, a weekly meeting will be held relating to matters that pertain to the daily functioning of the unit and in this regard work assignments will be handed out to the patients.

(C) Group Discussions: The philosophy or goal of such group discussions will be to confront the client with reality and support concrete plans that will pertain to continuing sobriety.

(D) Evening Program: Patients in the expanded program will be expected to attend the lecture series in the 28 Day Program as well as the Ex-patients Group and the A.A. meetings which begin on Sunday evening and run consecutively until Thursday evening, every week.

(E) Films: Educational films will be used to focus on various concepts in drug dependency with the purpose of increasing patient awareness.

(F) Recreation: The gymnasium and pool facilities of the Hospital will be made available to patients who are able and

willing to participate in and benefit from them.

(G) Relaxation Therapy: Patients will be introduced to a form of relaxation.

Capacity:

The bed capacity for the Treatment Orientation Program will not exceed ten (10), (including a maximum of 2 Day Care).

Staffing:

One day shift person will be assigned each week to participate as staff in the Treatment Orientation Program. The activities will include involvement in both the didactic presentations in the morning and the group discussions in the afternoon.

The Housekeeping staff in the Detox Unit will assist in the maintenance of the work therapy component.

The P.M. staff person assigned to the program each week, will be responsible for the patients involved in the program. The activities will include seeing that all the program patients attend the evening lectures which is part of the Family Program.

Participants:

Only those patients who are sufficiently detoxified and off mood-modifying medications will be involved in the

expanded program. A list of those involved will be posted daily.

Open Program:

The Program itself will be designed in such a manner as to allow new patients to be added daily.

Discharge:

The whole purpose of the expanded program is to attempt to design a workable follow-up program for the patients so that above and beyond the structured activities of the programs it will be expected that the program itself will generate a need for more individual counselling or group discussions. Further, as soon as patients enter a program such as this, they will begin immediately to formulate plans and be prepared to act on overcoming obstacles that will hamper their recovery. For example, an individual needing welfare shall make the initial contact for welfare but if the patient is in difficulty with the police, the courts, the supervisor, or the family, then they shall attempt to at least make the initial contact to come up with workable solutions to their problems.

Finally persons on the expanded program will be assigned to a specific treatment staff person to assure continuity in counselling and planning.

When a patient has completed the Treatment Orientation

Program, it is expected that the patient will be discharged within a 48 hour period.

Evaluation:

The criteria of "success" might be a significant decrease in the readmission rate over a given 6 month period. Hopefully, these concrete measures will allow for better job satisfaction on the part of the detox staff who will be able to feel that they are making noticeable treatment inputs. Another obvious measure that can be employed is to see if in fact there is an increase in the number of patients who participated in the outpatient counselling programs as well as the 28 Day Treatment Program.

TREATMENT ORIENTATION PROGRAM

	8:45-9:15	9:30-10:00	10:30-11:15	11:30-12:30	1:30-2:00	2:30-3:30	EVENING PROGRAM
MONDAY		LECTURE	Lecture 11:15-11:30 Work Therapy	LUNCH	FILM	GROUP DISCUSSION	7 P.M.
TUESDAY	RELAXATION TAPE	SPECIAL GROUP 9:30-10:30	FAMILY 10:30-11:30	LUNCH	FILM	GROUP DISCUSSION	7 P.M.
WEDNESDAY	RELAXATION TAPE		10:30-11:30 Lecture	LUNCH	FILM	GROUP DISCUSSION	7 P.M.
THURSDAY	RELAXATION TAPE		10:00-11:00 Lecture	LUNCH	FILM	GROUP DISCUSSION	9:30 P.M.
FRIDAY	9:00 A.M. Lecture		10:30-11:15 Group Discussion	LUNCH		PRE-PROGRAM ORIENTATION	

Breakfast 7:00 am/Supper 4:30 pm Sun. 8:00 pm A.A. Meeting/Tues. Chaplain Services Available

#40 Revised Feb./79

THE SHORT TERM TREATMENT PROGRAM RESIDENT'S HANDBOOK

Introduction to the Short Term Treatment Program (S.T.T.P.)

Welcome to the S.T.T.P., where all persons are sharing a common problem and striving to achieve the same goal - learning to cope with everyday living without alcohol and/or drugs.

We consider our program to be mainly educational. Each person is expected to participate in all aspects of the programme as scheduled. Each person on the program we assume, is motivated to alter his/her life style based mainly on the fact that each is taking four weeks out of their routine. This, we consider, is a significant investment.

The program consists mainly of films, educational lectures, group therapy, individual counselling, relaxation therapy, creative therapy and recreational activities. Spiritual counselling is also available on an individual basis. We will also introduce you to A.A., Al-Anon, Follow-up Society and Metro's Out-Patient services, which are supportive community based programs.

Approximately the first 3 to 5 days will be spent on an orientation group, after which time, focus will change to meet more individual and particular needs of the program members.

The persons on the program will be regarded as in a state of good general health; however, medical services will be available to those who request it for specific reasons and for physicals with the view to having the person put on Antabuse/Temposil regime. Mood altering drugs are not allowed on the program, medications deemed necessary will be dispensed by the night counsellor in consultation with the unit physician. The onus for taking prescribed medication is strictly the responsibility of the individual.

Feel free to approach the Short-Term Treatment Program Staff at any time regarding questions or problems.

Please remember to check the bulletin boards each day for scheduled activities.

You may leave the unit on your own time. Short-Term Treatment Program Staff must be notified if visiting the hospital or before leaving the grounds.

Visitors may be received during the lunch break and in the evening. If permitted by your counsellor, you may be excused from a certain activity to receive visitors. On many occasions, visitors can be invited to join in an activity which is going on at that time, (the exception being Group Therapy). On specific occasions family members or employers will be asked to participate in the program.

Philosophy of Treatment

The Staff of the S.T.T.P. share a common belief, in that drug dependency is a condition which is developed by excessive consumption or intake of a preferred drug to such an extent that drug consumption interfers with, and effects bodily and mental health, causes financial, social, and family and employment problems but does make easy an already established life style.

All activities included in the program have been selected to help us achieve our objective with those of you who are drug dependent and the people with whom you live and/or work.

We believe:

1. that drug dependency to be excessive consumption, with the degree of dependence on the preferred chemical so high that it shows mental interference, affects bodily and mental health, interpersonal, economic and social relationships,
2. that treatment should be based on a program which stresses reality,
3. that each person on the program should be dealt with as an individual with individual needs and problems.
4. that treatment should help the individual to learn how to fulfill their needs in a healthy way,
5. that we should be able to recognize the strengths of each person and emphasis should be placed on the

evident or potential strengths of each individual,

6. that treatment should include involvement with the family and/or other significant individuals, in degree, as indicated,
7. that staff attitude and motivation, both directly and indirectly, affect the resident's attitude and motivation,
8. that staff must become involved in a professional relationship which is based on responsibility, acceptance, interest, honesty, firmness and flexibility when necessary,
9. that good communication is essential, and lines of communication between both staff and patients should be open and direct,
10. that there should be reciprocal co-operation and communication with other Metro services and appropriate community agencies and organizations, and
11. that education is a never-ending process and that everyone, residents and staff, has a state of readiness to learn and change.
12. that an individual can be motivated to learn.

Program Objectives

The Metro Drug Dependency Centre provides a 28 Day Short Term Treatment Program to:

1.) Interrupt the repetitive pattern of drug abuse.

2.) Provide information on the effects of alcohol and drug abuse as it affects him/herself family employer and close associates.

3.) Help him/herself to face reality.

4.) Develop a desire for personal achievement whereby he/she will improve his/her self esteem.

5.) Develop a feeling of self understanding.

6.) Aim at restoring physical, spiritual and emotional health.

7.) Offer acceptable alternate behaviors.

8.) Aim at restoring the resident to resume his/her role as a responsible individual in society.

9.) Assist the resident in making concrete follow-up plans.

Residents Objectives

By the end of 28 days with full participation in group therapy, films, lectures, individual counselling, creative and relaxation therapy, spiritual counselling and in consultation with other supports including family, employer, other agencies and weekend practice.

1. To discuss the physical, psychological, social aspects and the consequences of drug dependency.

2. To recognize your personal dependency as it relates to drinking patterns and life style.

3. To describe your actual life situation.

4. To recognize your system of defence mechanisms used

to protect drinking patterns.

5. To accept your situation.
6. To describe your ability to change this situation.
7. To express a feeling of self-esteem.
8. To describe personal strengths.
9. To describe alternate behaviours in dealing with problem situations.
10. To develop productive methods for use of leisure time.
11. To abstain from alcohol and other mood-altering drugs.
12. To complete at least one creative therapy project.
13. To develop a feeling of personal responsibility for your behaviour.
14. To attain physical health.
15. To set personal goals for the 28 Day Program.
16. To plan a personal follow-up plan program.
17. To participate as a member of the resident groups.

So that the counsellor and yourself agree that an effort has been made to meet these goals.

Staff Objectives

1. Given the goals and objectives of the short term treatment program and no less than two days; to make clear said goals and objectives to the extent that the residents, relatives and the referral source demonstrate an understanding of said goals and objectives.

2. Given a resident group of no more than 14 and the goals and objectives of the short term treatment program and a group setting to conduct resident needs assessment to the extent that the staff and a majority of the residents involved agree that an accurate assessment has been done.

3. Given the established 28 day treatment program, group of no more than 14 residents, their stated needs, available resources, and 20 daily sessions lasting no more than 1½ hours per session to facilitate a group learning experience to the extent that a majority of group members participate actively in the experience and are able to describe the physical, psychological and social aspects of drug dependency.

4. Given the established 28 day treatment program a group of no more than 14 residents, their stated needs and available resources to provide learning experiences in the form of lectures and/or audio visual presentations to the extent that there is a daily AV presentation and at least eight lectures over the course of the program.

5. Given the established 28 day treatment program a group of no more than 14 residents, their stated needs, available resources and one hour per week to counsel each resident in a one to one situation to the extent that the resident understands the life situations which effect him/her and is aware of alternatives.

6. Given the established 28 day treatment program and a group of no more than 14 residents, their stated needs, available resources and available evaluation data to participate in program development to the extent that staff can propose changes in the form of alterations, modifications, deletions, and additions deemed necessary by the group to the Treatment Supervisor.

7. Given the established 28 day treatment program and a group of no more than 14 residents, their stated needs and available resources to administer the program on a day to day basis to the extent that a majority of residents agree that their needs are being met and the Treatment Supervisor in consultation with the Regional Co-ordinator agrees that this administration is acceptable.

8. Given the established 28 day treatment program a group of no more than 14 residents, their stated needs, available resources and no less than three hours per week to maintain an evaluation system including assessment of program effectiveness, and resident progress and the evaluation of assessment procedures and tools to the extent that a majority of residents, staff and the Treatment Supervisor in consultation with the Regional Co-ordinator agree that the evaluation system is satisfactory.

9. Given the established 28 day treatment program, a group

of no more than 14 residents, their stated needs and available resources to assist the residents in the development of personal follow-up plans to the extent that the individual resident and staff agree that the plan can be implemented.

10. Given the established 28 day treatment program, a group of no more than 14 residents, their stated needs and available resources to promote family (and/or other significant person) involvement in the treatment and recovery process to the extent that they are able to describe their role in this process and accept their responsibility for it.

In an attempt to expose the resident to activities that will usefully occupy his/her leisure time, he/she will be introduced to a limited amount of activities. These activities have been selected to offer to the resident a source of physical and mental well being. For some residents this will be either a totally new experience or an experience which had not been felt for many years. However, due to the time constraints the resident can only be expected to "get started" on these activities and further it is hoped that some variation will be carried on beyond the program. The activities are as follows:

1. Yoga will be offered four times a week for one hour. The exercise offers physical activity as well as relaxation.

It will be taught in such a fashion that the resident will be able to practice on his/her own time.

2. Physical exercise includes activites like volley-ball, swimming, jogging, etc.; it includes team sports and individual program. Each resident is expected to attend the program daily for at least one hour and expected to exercise to his/her capacity and attempt to increase his/her capacity.

3. Creative therapy consists of a variety of hand skill activities which will vary in cost. This program encourages the resident to get involved in some type of project. If the resident wishes to take them home he/she pays only for the cost of the materials, however, he/she is under no obligation to purchase projects. This program will also be offered daily with one special evening program.

Educational Inputs

Education in our program will initially follow two routes which will merge in the later phases of the program. One focus will be on the individual as a person who had a drinking problem thereby leading to an attempt to teach the person about all aspects of alcoholism, e.g., its signs, symptoms, development and even more important by recovery. This aspect of the program will be delivered by the presentation of a lecture or film followed by a discussion period.

The other focus will be on the individual as a person and thereby deal with interpersonal relationships and

effective ways of dealing with reality while enhancing self-esteem, thus the purpose of group therapy.

Each person will also be expected to get involved in individual counselling with his/her assigned counsellor. This will allow the resident to deal with unique aspects of his/her situation. When applicable, your family, employer or close associates may be contacted by your counsellor so that they may become involved in your treatment.

Finally, the resident will be introduced to follow-up services which include the Metro Out-Patient Clinic, Alcoholics Anonymous, Al-Anon, Al-Teen, Follow-up Society and Public Health. These agencies and organizations are considered as important and necessary extensions of the Short Term Treatment Program. The process of recovery is considered to be a two to five year process of which the Short Term Treatment Program is only the first four weeks.

Supervision

The Short Term Treatment Program, it is expected, will consist of residents who are striving to be mature and responsible adults who have made a commitment to gain help. Treatment staff will be available Sunday night through Friday. The treatment staff will not be expected to serve a policing function.

Passes

Weekends are also considered to be part of the program. The residents are expected to go home on weekends, leaving the program at noon Friday and returning 7:30 p.m. on Sunday.

Meals

Times for meals will be posted on the schedule, but because this service is provided to us by the Hospital, residents are expected to wear their assigned arm bands. This is to assure proper billing for meals. The resident does not pay for his/her meal. Day Care patients will be issued ident-a-cards rather than arm bands.

Bed Time

Residents are expected to be in their beds not later than after the midnight news. If one is unable to sleep a counsellor is available for counselling.

Antabuse

Antabuse is a drug used in the treatment of alcoholism. It is an aide for the person who desires to remain sober so that the learning of alternate life styles without alcohol may be given to best advantage. It creates a sensitivity to

alcohol and causes a severe reaction when the person ingests even small amounts of alcohol. Therefore, the person must be committed to the idea that he/she is going to drink no alcohol.

Dosage: It is suggested that antabuse be taken prior to bedtime. When starting antabuse it is suggested that 500 mg. be taken for four days followed by daily dosages of 250 mg. Because of the severity of the antabuse reaction (when alcohol is ingested), antabuse must be prescribed by a physician. Arrangements for an antabuse assessment by a doctor will be arranged by one of your counsellors.

Effects of Alcohol in the Antabuse-Treated Resident: Antabuse plus alcohol produces (1) flushing, (2) palpitations, (3) dyspnea (shortness of breath), (4) Hyperventilation, (5) Acceleration in pulse rate, (6) Fall in blood pressure, (7) Nausea, (8) Vomiting, and (9) occasionally collapse.

The duration of the reaction varies from 30 minutes to several hours or as long as there is alcohol in the blood. The intensity of the reaction varies with each individual and is proportional to the amounts of antabuse and alcohol ingested. Symptoms will appear after drinking alcoholic beverages of any type, such as beer, wine, rum, or alcoholic preparations, e.g. tonics and cough mixtures. The longer the person remains on therapy the more sensitive he becomes to alcohol.

Warning: Antabuse should never be administered to a resident when he is in a state of alcohol intoxication or without his full knowledge. A period of 24 hours following the last drink of alcohol should elapse before antabuse is resumed. The effect of antabuse may last in some cases 14 to 18 days after treatment is discontinued (temposil - 48 hours).

Precautions: Every resident receiving antabuse should carry an identification card stating he/she is receiving antabuse.

Duration of Program: Depending on the individual person, treatment may have to be given for several months or several years. It must be remembered antabuse treatment provides only sober time, how productive this time is depends on what the person does to alter his/her life style productivity.

Resident Program Council

As the Short Term Treatment Program functions on a self-help basis, the program council allows the resident to voice his/her opinion and accept responsibility for recreation, cleanliness and discipline on the unit.

The resident council meeting is presently being held every Friday from 9 to 9:30 a.m. and includes all residents. Staff members will attend, to answer questions or listen to any realistic "beefs" the resident may have. Likewise, the staff will also take this time to air complaints. A council chairperson and assistant will be selected every 2 weeks

and the entire council will be responsible for unit maintenance (each resident will be assigned unit duties).

Program Rules

The No rules: (1) No alcohol

(2) No drugs

(3) No smoking in beds

(4) No sexual activity

(5) If there is poor participation and generally lack of interest and co-operation from the residents, a decision will be made by staff regarding an early discharge.

(6) Violation of the above rules may result in early dismissal.

Residents are expected to adhere to the schedule and minor regulations as posted. If one has a valid reason he may be excused from any activity, e.g. appointments. The program will not be policed therefore we ask each resident to act maturely in a spirit of co-operation and respect not forgetting the primary reason why each is involved in the treatment program.

Admission

Prior to admission to the Short Term Treatment Program the client must abstain from drugs and/or alcohol for at least 5 days.

Admission to the Short Term Treatment Program is not automatic, that is, there is a selection criteria. In essence, the resident will be screened to assure that he/she will gain some benefit from taking the program. On admission each resident will be asked to sign (1) a release of information form, (2) a voluntary admission form, (3) an antabuse/temposil form must be signed by those already taking that prescribed medication and (4) a clothing sheet must be signed.

The Short Term Treatment Program will screen the resident as to suitability. Factors to be reviewed are: (1) motivation, (2) family situation, (3) employment situation, (4) previous treatment, (5) severity of the problem, and (6) referral source, (7) educatability.

WEEKLY SCHEDULE

MONDAY

7:00 - 8:00	Breakfast
8:00 - 8:30	Work Therapy
8:30 - 8:45	Break
8:45 - 9:15	Exercises (+ A Walk outdoors weather permitting)
9:15 - 9:30	Break
9:30 -10:30	Creative Therapy/Film
10:30 -10:45	Break
10:45 -12:15	Group Therapy
12:15 - 1:15	Lunch
1:15 - 2:15	Creative Therapy/Free Time
2:15 - 2:30	Break
2:30 - 4:30	Group Therapy
4:30 - 5:30	Supper
5:30 - 5:45	Break
5:45 - 6:45	Film
6:45 - 7:00	Break
7:00 - 8:00	Family Program

TUESDAY

7:00	- 8:00	Breakfast
8:00	- 8:30	Work Therapy
8:30	- 8:45	Break
8:45	- 9:15	Exercises (+ a Walk outdoors weather permitting)
9:15	- 9:30	Break
9:30	- 10:30	Creative Therapy/Film
10:30	- 11:00	Free Time
11:00	- 12:00	Clergy Group
12:00	- 1:15	Lunch
1:15	- 2:15	Clergy Group
2:15	- 2:30	Break
2:30	- 3:30	Creative Therapy/Free Time
3:30	- 4:30	Free Time
4:30	- 5:30	Supper
5:30	- 5:45	Break
5:45	- 6:45	Film
6:45	- 7:00	Break
7:00	- 8:00	Follow-up Society
8:30	- 9:30	Narcotics Anonymous (N.A.) Meeting (Open) - 3rd Tuesday of every month

WEDNESDAY

7:00	- 8:00	Breakfast
8:00	- 8:30	Work Therapy
8:30	- 8:45	Break
8:45	- 9:15	Exercises (+ a Walk outdoors weather permitting)
9:15	- 9:30	Break
9:30	- 10:30	Creative Therapy/Film
10:30	- 10:45	Break
10:45	- 12:15	Group Therapy
12:15	- 1:15	Lunch
1:15	- 2:15	Creative Therapy/Free Time
1:45	- 3:30	Women's Group
2:15	- 2:30	Break
2:30	- 4:30	Group Therapy
3:30	- 4:30	Orientation to Creative Therapy (First Week Only)
4:30	- 5:30	Supper
5:30	- 5:45	Break
5:45	- 6:45	Film
6:45	- 7:00	Break
7:00	- 8:00	Family Program

THURSDAY

7:00	-	8:00	Breakfast
8:00	-	8:30	Work Therapy
8:30	-	8:45	Break
8:45	-	9:15	Exercises (+ a Walk outdoors weather permitting
9:15	-	9:30	Break
9:30	-	10:30	Creative Therapy/Film
10:30	-	10:45	Break
10:45	-	12:15	Group Therapy
12:15	-	1:15	Lunch
1:15	-	2:15	Creative Therapy/Free Time
2:15	-	2:30	Break
2:30	-	4:30	Group Therapy
4:30	-	5:30	Supper
5:30	-	5:45	Break
5:45	-	6:30	Film
6:30	-	8:30	Creative Therapy (Residents will be notified as to individual class time)
8:30	-	9:30	Closed A.A. Discussion Group

FRIDAY

7:00	- 8:00	Breakfast
8:00	- 8:30	Work Therapy
8:30	- 8:45	Break
8:45	- 9:15	Exercises (+ a Walk outdoors weather permitting)
9:15	- 9:30	Break/Free Time
9:30	- 10:00	Resident/Staff meeting
10:00	- 11:00	Creative Therapy
11:00	- 11:15	Break
11:15	- 12:00	Film
12:00		Weekend Passes Begin

SUNDAY

3:00		Doors open on unit
8:30	- 9:30	Open A.A. Speaker Meeting

SHORT TERM TREATMENT PROGRAM

WEEKEND EXERCISES # 1

Well, you have just finished your first week on the Short Term Treatment Program and you are preparing yourself for your first weekend in the community while participating in the treatment.

It is possible and very likely that you are experiencing one of the following: fear, excitement, anxiety, doubt, peacefulness; or even a mixture of several. You are looking forward to going home but are anxious about whether or not you can stay sober, or perhaps you are afraid of facing your family but feel good about the positive change in you. Whatever it is that you are feeling it's important that you talk about it to someone, your wife, parents, children, a close friend.

So....this weekend, your assignment is:

1. To talk about the program; what you did and how you felt about doing it.
2. To talk about you, and how you are feeling after your week on the program.

The exercise will be shared and discussed on Monday morning during the group session.

SHORT TERM TREATMENT PROGRAM

WEEKEND EXERCISES # 2

You have reached mid point in the program, do you notice changes in yourself? Physically? Mentally? Emotionally? Are you more interested in going out for the weekend, or is the fear still a part of you?

Your family, the people closest to you, mean so much in helping you through the difficult moments. Your period of drinking has had some pretty negative effects on you, hasn't it? Well, the people close to you were effected by your addiction, too. Maybe you don't want to think about that, but its reality and reality is part of staying sober.

Your assignment for this weekend is:

1. To talk to your wife, children, parents and/or another relative or friend who experienced your addictive behavior. Ask them how they were effected by your behavior.
2. To share with the same individuals how your behavior effected you.

SHORT TERM TREATMENT PROGRAM

WEEKEND EXERCISES # 3

Well, you're starting your third program weekend today. Are things beginning to fall into place? Has the haze cleared and are your future plans a little bit more certain? Perhaps you're still anxious, still nervous; why not share those feelings with someone before you leave. Your exercise for the weekend are:

1. Share with someone, (a family member, relative, friend) one positive change which you see in yourself since starting the program.
2. Talk with someone about something which you are still working on to change. Ask them how they can help you, or tell them, if you already know.
3. Discuss some plans you might have for yourself after you finish the program. Talk about whether they are realistic and can be attained.

Have a good weekend!

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